USER'S MANUAL: VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)

Commonwealth of Virginia

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- Bonnie Davis, RN, Petersburg Health Department
- Patricia DeZern, Social Worker Coordinator, Columbia Chippenham Medical Center
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HOW TO OBTAIN DOCUMENTS

Information related to the Uniform Assessment Instrument (UAI) is available as follows. A nominal charge may apply to cover the cost of copying and distribution.

To get additional copies of this manual, contact the following:

DMAS Order Desk, North American Marketing*
703 Carolina Avenue, Richmond, VA 23222
Telephone: 804-329-4400

Virginia Department of Social Services
Adult Services Program
730 East Broad Street, Richmond, VA 23219
Telephone: 804-692-1299

To get copies of the Uniform Assessment Instrument, contact:

DMAS Order Desk, North American Marketing*
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To get copies of the User's Manual: Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents of Adult Care Residences or the Uniform Assessment Instrument for Private Pay Residents of Adult Care Residences, contact:

Virginia Department of Social Services
Adult Services Program
730 East Broad Street, Richmond, VA 23219
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To get copies of Medicaid provider manuals (e.g., Nursing Home Manual, Preadmission Screening Manual), contact:

DMAS Order Desk, North American Marketing*
703 Carolina Avenue, Richmond, VA 23222
Telephone: 804-329-4400

To get copies of the Assessment in Adult Care Residences: A Manual for Assessors, contact:

Virginia Department of Social Services
Adult Services Program
730 East Broad Street, Richmond, VA 23219
Telephone: 804-692-1299

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TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)

Background

The Commonwealth of Virginia has demonstrated an interest in assessing the long-term care needs of the elderly and people with disabilities to provide appropriate services and to develop an effective and efficient system of quality, affordable programs and services. In 1979, a Statewide Survey of Older Virginians was completed which provided information on characteristics of non-institutionalized older Virginians and their service needs and established a baseline for estimating future service needs. The Older American Resources and Services ("OARS") questionnaire, developed at Duke University, was used to assess the functioning of individuals on five dimensions: social resources, economic resources, mental health, physical health and activities of daily living.

In 1982, Virginia Medicaid's Nursing Home Preadmission Screening Program began using the Long-Term Care Information System and Assessment Process, developed by Angela Falcone, to record assessment information and apply decision criteria for determining eligibility for Medicaid-funded long-term care services. The Falcone form adopted a version of the Katz Index of Activities of Daily Living and the federal *Patient Classification for Long-Term Care System*, which was a culmination of over 25 years of developmental activity on geriatric assessments. The standardized decision criteria, which are used to determine eligibility for Medicaid-funded services, were developed by the Virginia Department of Medical Assistance Services (DMAS).

In 1990, the Virginia General Assembly recommended a Case Management for Elderly Virginians Pilot Project ("Pilot Project") be established to target limited public resources to the elderly at highest risk of institutionalization; coordinate the delivery of multiple services to avoid institutionalization; facilitate client access to services; support and enhance family caregiving; and provide the most cost-effective services. The General Assembly also requested a uniform assessment instrument be developed. Such an instrument would be used statewide for the provision of all publicly funded long-term care services. The uniform assessment instrument, developed for the Pilot Project, was adopted for this purpose and became known as the Virginia Uniform Assessment Instrument or UAI.

In 1992, as the Commonwealth of Virginia's long-term care policy evolved to include a stronger emphasis on home- and community-based care services, the Secretary of Health and Human Resources convened a committee to revise and refine the UAI that had been used for two years in the Pilot Project. The committee was composed of representatives from the Departments of Health, Mental Health, Mental Retardation and Substance Abuse Services, Social Services, Rehabilitative Services, Aging, Visually Handicapped, and Medical Assistance Services, and representatives from each of the three Pilot Project sites. The charge of the committee was (1) to redesign the assessment instrument used in the Pilot Project to include the basic dimensions required to make referrals to and/or authorizations for case management services in all settings and to move toward standardized language, assessment and criteria across other long-term care services, ranging from home services, community-based services, through adult care residential living and assisted living, to preadmission screening for and continued stay in nursing care facilities, and (2) to develop a case management information system based on the information obtained from the UAI.

The committee met over eighteen months to review and revise several drafts of the assessment instrument. Pre-tests of various drafts of the instrument were performed throughout the process; including its use in a statewide study of service intensity needs in adult care residences. Community and hospital nursing home preadmission screening teams also provided input on the utility and effectiveness of the draft. As the result of the pre-tests, a short assessment was designed to determine whether a full assessment is warranted or for clients with only limited service or information needs.

In 1993, the Virginia General Assembly passed House Joint Resolution 601 requiring that all public health and human resources agencies implement a uniform assessment instrument, common definitions, and common criteria by July 1, 1994, for clients accessing publicly funded long-term care services in the Commonwealth. Also during the 1993 General Assembly session, Senate Bill 1064/House Bill 2280 established the statutory basis for the use of a uniform assessment instrument for all residents of adult care residences. The UAI that was developed by the interagency committee described above was subsequently adopted for use across all publicly funded long-term care services.

In the Spring of 1994, 3,000 persons statewide were trained on the use of the UAI. As of July 1, 1994, all publicly funded health and human resource agencies in Virginia, including the local departments of social services and health, area agencies on aging, staff of the Department of Rehabilitative Services, Medicaid funded long-term care service providers, and Medicaid nursing home preadmission screening teams, began using the UAI to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring client care needs across agencies and services.

The UAI ensures easy and equitable access to appropriate services for clients at all levels of long-term care. For providers, it provides a comprehensive picture of the clients and the clients' needs and is intended to facilitate the transfer and sharing of client information among providers. For the agencies of the Commonwealth, it aids in the case management, monitoring, evaluation, and balancing of long-term care services needs of each individual requiring such services. The UAI has used the well-known, common definitions established in the 1960s and 1970s and establishes the framework for decision criteria to target services to those in various stages of need. Virginia has developed standardized decision criteria that are tied to the UAI. These include the criteria for targeted case management services for the elderly; levels of care in adult care residences, Medicaid-funded nursing home or community-based care, and Medicaid case mix reimbursement for nursing facilities. A client-level data base has also been initiated to capture information from the UAI to measure the quality, necessity, and provision of long-term care services in Virginia.

INTRODUCTION TO USING THE UAI

The purpose of the Uniform Assessment Instrument (UAI) is to gather information for the determination of a client's care needs and service eligibility, and for planning and monitoring a client's care across various agencies and long-term care services. The UAI is a multidimensional, standardized questionnaire, which assesses a client's social, physical health, mental health, and functional abilities, and it provides a comprehensive look at a client. The UAI fosters the sharing of information between providers, and assessors are encouraged to share information about a client in an attempt to avoid duplicative paperwork.

This manual provides general instructions regarding the use of the UAI, followed by specific instructions for the administration of each section. Assessors should become familiar with this manual and use it as a reference document. The general principle, which should guide the assessor, is to get the best, most complete, and most accurate information in every case.

At the end of the manual are Appendices, which include supplemental information and referral indicators. Referral indicators are designed to provide guidelines for situations when a more specialized assessment may be required. The indicators do not cover every client need nor are they intended to be comprehensive.

The UAI is required to be used by publicly funded human services agencies in Virginia, including the local departments of social services, area agencies on aging, centers for independent living, state facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services, community services boards, and Medicaid nursing home preadmission screening teams. For information on specific requirements on the use of the UAI for publicly funded long-term care and aging services, contact the appropriate agency. For assessment of adult care resident applicants and residents, refer to the manual *Assessment in Adult Care Residences: A Manual for Assessors* (published by the Virginia Department of Social Services). For screening of individuals seeking nursing facility admission or community-based services, see the *Medicaid Nursing Home Preadmission Screening Manual* (published by the Department of Medical Assistance Services). Also see Appendix I for indicators for referrals to Medicaid-funded long-term care services.

Short Assessment (UAI, Part A)

The UAI is comprised of a short assessment and a full assessment. The short portion is designed to be an intake/screening document, which allows for a brief review of functional status, current service arrangements and unmet needs. The purpose of the short assessment is to assess the severity of a client's situation and decide whether or not a full assessment is warranted. Since intakes are frequently completed over the phone, questions have been organized to complement a phone discussion with a client or caregiver while providing a format that is suitable as the first component of the full assessment.

Full Assessment (UAI, Part A and Part B)

The full assessment is a multi-dimensional evaluation of client functioning, and it is designed to gather sufficient information about the client, his or her needs, and his or her strengths in order to begin a service plan. It encompasses the short assessment and has 4 major content areas: Identification/Background, Functional Status, Physical Health Assessment and Psycho-Social Assessment. The final section of the UAI is an Assessment Summary, which includes a Caregiver Assessment. The full assessment is to be completed during a face-to-face interview with the client. Information gathered during the intake/screen should be checked for accuracy, particularly if this information was obtained over the phone. Also, the full assessment interview with the client is used to gather specific information about functional status (Section 2).

Interviewing Process

Prior to beginning the interview, the assessor should take time to establish rapport (i.e., building trust) with the client and/or caregiver. Suggestions to begin an interview include engaging the individual in "small talk" such as discussing the weather or something positive and lighthearted. Developing rapport will make the interview go more quickly and the conversation more enjoyable. If the client feels comfortable, he or she will speak more openly, allowing the assessor to gather valuable, necessary information. Developing rapport with the client will also result in a better understanding of him or her. Knowledge of the client will help the assessor direct the conversation and know when to ask additional questions.

The preferred source of information is the client. If there is another person in the room when the client is being interviewed, questions should continue to be directed to the client. If others who are present try to answer questions for the client, they should be asked not to assist with responses or provide reminders or hints. This is particularly important when asking the client subjective questions such as how satisfied he or she is with family relationships.

In some situations (such as a cognitively impaired client), it will be necessary to use other sources of information such as the primary caregiver, family members, other helpers, friends, neighbors or provider staff. For the completion of some sections of the UAI, the assessor may need to interview other professional staff such as physicians, nurses, or social workers. It is important to note on the form when sources other than the client are used to gather information. Also, it may be necessary to obtain a translator or some other spokesperson for clients who are non-English speaking or who have communication problems. Appendix J outlines strategies for interviewing clients with communication problems and/or other limitations.

Although it is recommended, it is not necessary to seek information in the exact order in which it appears on the form. The form is designed with a logical flow and is intended to appear reasonable to the client. However, because clients will present information in their

own way, it is not necessary to ask questions which have already been answered in the course of the interview; just record the answer already given.

Confidentiality

Prior to completing the assessment, assessors should obtain a written release of information statement signed by the client or his or her authorized representative. In doing so, it is important to discuss with clients about the importance of sharing information from the UAI and engaging in collaborative relationships with other service providers (who are also bound by laws of confidentiality). Information sharing ensures that clients get the help they need; it ensures the continuity of services; it avoids duplication and achieves efficiency; and it ensures coordinated services.

When authorizing the release of confidential information, the decision of how widely the information shall be shared resides solely with the client. It is critical that agencies respect and protect the client's interests. However, efforts to safeguard information should not unnecessarily restrict a client's access to services when state and federal laws and regulations allow for appropriate exchange of information. See Appendix B for specific information on the *Consent to Exchange Information* form.

Asking Questions

It is important to obtain valid and reliable assessment information. The following suggestions are designed to ensure that responses to assessment questions will be accurate and useful.

- Always remain neutral. Do not make statements or offer nonverbal cues that might suggest that a particular response is correct or incorrect, good or bad, or similar to or different from other respondents. Be careful not to show surprise at certain responses; this reaction might suggest that the response given was unusual or inappropriate.

- If a question is applicable, ask it exactly as it is worded. Deviations from the original wording, even subtle ones, can lead to changes in the responses.

- Read each question slowly and in a clear voice. With practice, it is possible to read the questions in a conversational tone that helps to maintain the client's interest.

- Be careful to properly follow any skip patterns. Ask every question, with the exception of those that the instructions require you to skip.

- Repeat questions that are misunderstood or misinterpreted by reading them again exactly as worded.

- Keep the respondent focused, perhaps by asking the next question, or by repeating the last one if an appropriate answer has not been provided.

- Shield the questions from the respondent's vision, unless instructed otherwise. Respondents tend to try to read ahead and look at how past responses were recorded, and these actions tend to make them less attentive to the questions being asked.

- Before accepting a "don't know" response, use a neutral probe to help stimulate an answer. Appropriate ways of using probes are described in the next section.

Using Probes

Many times respondents say they do not know the answer to a question when, in reality, they are still thinking about it. At other times, they give answers that do not really seem to fit the question or give answers that are very general when a more specific response is required. On these occasions use a neutral probe to help the respondent answer or get back on track. Neutral probes are questions or actions that are meant to encourage a response, or a more complete response, without suggesting what the answer should be. The following ways of providing neutral probes are useful.

- Repeat all questions that are misunderstood or that lead to "don't know" responses.

- Give the respondent time to answer. An “expectant” pause can signal the person that a more complete response is needed and give him time to organize his thoughts.

- Ask a neutral question, such as "Do you have more to say about that?" or "Is there anything else?"

- If the question has specific response categories, read the categories and ask the respondent which is more appropriate to him or which fits him best.

- Ask the respondent to provide further clarification, such as "Please tell me a little more about that" or "Please explain that a little further for me."

Probes must not give the client any clues about what the response should be. Probes that begin "Don't you think that . . ." or "Most people have told me . . ." or "I assume what you're trying to get at is . . ." all serve to direct respondents toward particular answers, and are less likely to represent the individual's true response.

Completing the Assessment

Each page of the UAI contains an essential set of *minimum* data to be recorded in the spaces provided. Assessors may wish to use the blank space and comments sections to gather additional information that is helpful. The assessor may also attach additional pages to expand on the comments entered, if necessary. Some specific points about completing the assessment are listed below.

- Assessments must be legible and maintained in accordance with accepted professional standards and practices. All UAIs must be signed with the name and professional title of the assessor and completely dated with month, day, and year.

- Any changes made to the assessment must be legible and made with a single line to cross out old information and with new information neatly entered and initialed.

- All information must be completed in its entirety.

- Some of the questions are closed-ended with a fixed set of responses, which are incorporated into a client level database. As a result, only "codable" responses are acceptable, and assessors may have to probe respondents for answers.

- Most questions call for one answer; if two or more are given, probe for the response which comes closest to the client's situation. In probing for answers, the assessor should take care not to influence the answer or irritate the respondent.

- Occasionally an accurate answer may not completely fit one of the answer options. In this case, determine which option best fits the situation. If a question provides for a "yes" or "no" response listed in columns, each response must be checked appropriately. If "yes" is marked, use the space available to provide additional information if needed.

- If the answer to a question is unknown, write in "Unknown". Do not leave the question blank and do not mark "No". There is an important difference between "No" and "Unknown". "No" means the question was asked and the response was no or negative. "Unknown" means that the question was not asked for some reason or the answer is truly unknown. The assessor should seek information from other persons knowledgeable about the client's situation in order to complete the assessment. The use of "Unknown" should be avoided.

- Some of the closed-ended questions have an "Other" category. Please use the space next to "Other" to specify/describe an answer which does not fit one of the categories listed. "Other" should be used on a limited basis. Most answers should fit into one of the provided categories.

- Some questions are open-ended. Although these are not intended to be included in a database, they are important for gathering information about the client. These questions are followed by blank spaces rather than a list of possible answers. Responses to open-ended questions should always be probed to make clear exactly what the respondent has in mind, to be sure the answer is relevant and to get additional ideas on the subject.

- Some of the questions are preceded by pre-worded questions or prompts. These are enclosed in shaded boxes. This is most common in the Psycho-Social Assessment section. Please follow the pre-worded suggestions in order to ensure that all assessors ask the questions in the same way.

- The psychosocial section of the assessment contains an optional set of questions (found in italics) which can be used to give the client a score on the modified Mini-Mental State Examination (MMSE).

Some final points about completing the assessment are:

- Use a check (_) or an "X" to mark the appropriate response.

- Read down lists to familiarize the respondent with the range of responses.

- Where an answer consists of several options separated by a slash, circle the specific answer, or both if appropriate. An example of this is the Communication of Needs question on page 1. If the third response (Sign Language/Gestures/Device) is the correct answer, put a check next to this line and specify the appropriate option with a circle.

- Make sure every question has the appropriate number of responses recorded.

- In some sections of the UAI, there are small numbers to the right of the variable. These are for coding purposes only and are not used by the assessor in completing the assessment.

Changing Assessment Information

Information on the assessment may be revised in order to change incorrect or inaccurate information. All information collected during the intake/screen (or short assessment) will need to be verified and possibly changed at the time of the on-site assessment. Information is also changed if it is determined that incorrect or inaccurate information was gathered on the assessment (and subsequently entered into a data base) anytime during the period in which the client's case was open.

Note to Nursing Home Preadmission Screeners and Adult Care Residence Assessors: If a UAI is changed after it has been submitted to the Department of Medical Assistance, and the change does not indicate a change in level of care, the change should be clearly noted on the UAI and initialed and dated by the assessor. It does not need to be resubmitted to DMAS unless there has been a change in level of care.

Reassessments

A reassessment is an update of information at any time after the initial assessment. It is a formal review of the client's status to determine whether his or her situation and functioning have changed. A client's situation and functional abilities can rapidly change. Temporary changes in an individual's condition are those that can be reasonably expected to last less than 30 days. Such changes do not require a new assessment. Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, or a well established, predictive, cyclic pattern of signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

In order to maintain a comprehensive assessment, a reassessment should be completed whenever there is a permanent, significant change in the resident's condition. A permanent change is one, which is expected to last 30 days or more. All reassessments are to be completed with the client and, if possible, the appropriate informal caregiver(s). All services in place are to be reviewed for quality and appropriateness. If the client's needs have changed, the service delivery or care plan is adjusted based on information from the reassessment.

A reassessment can be done on a previously completed assessment form. In this case, clearly mark the reassessment information by crossing out old information, legibly entering new information, and initialing all changes. The UAI should be marked as a reassessment and the reassessment date recorded in the upper right-hand corner on page 1. The UAI is designed to accommodate the initial assessment and a reassessment. When a previously completed UAI is used for a reassessment, changes made to the form as part of the reassessment process must be clearly made in red ink and circled in red.

New information can be added as necessary, but the assessor must ensure that the UAI remains legible. Use a new UAI form as needed and transfer only the most recent information to the new form. Always maintain the previous UAIs with the client's record to provide an accurate case history. After each reassessment, the "Assessment Completed By" section (page 12 of the UAI) must be completed to document who completed the reassessment or made changes. The assessor must completely date his or her signature with month, day, and year.

SECTION I OF THE UAI: IDENTIFICATION/BACKGROUND

In the upper right-hand corner of the UAI is space to record the date of the screen, date of the assessment, and date of the reassessment. The screen date refers to the date when the short (or screen) component of the instrument is completed. The assessment date is when the complete assessment (short and full) is done. These dates may be the same, or the assessment date may be later than the screen date. The reassessment date is the date when the client is reassessed, either during a periodic review or when there is a change in the client's condition. The reassessment date will *always* be later than the assessment (and screen) dates.

Name and Vital Information (UAI, Page 1)

Social Security Number (SSN) (UAI, Page 1)

The SSN is a nine-digit number, which will be used to track information on all clients who are assessed. It is important that every person have a **unique** number. Most clients should have a SSN, but you will find that many female clients use their Medicare number as their SSN and/or their husband's SSN as their own. Medicare numbers are SSNs with an additional letter added. A Medicare number ending with the letters A, J, M, or T is equal to the female client's own SSN. However, a Medicare number ending in B or D is the husband's SSN. B means the husband is still alive and D means the husband is deceased. Assessors can use the Medicare number ending in D as the wife's SSN since the husband is deceased.

On occasion, the assessor will need to generate a dummy social security number for a client. This will happen when a female client only has her husband's number and he is still alive, or when there is no number to be found. In the cases where the wife is using the husband's SSN, generate a dummy number for the wife in the following way: 777-XX-XXXX. The 7's are the dummy numbers and the Xs are the remaining numbers of the husband's SSN. In some cases it will be necessary to dummy the entire 9-digit number. The most critical feature of the number is that it is unique to that client.

Record the full name of the client (last, first, and middle initial); the client's full address (street, city, state and zip); the phone number at the client's home address (area code and number) and the city/county code of the client's home. The telephone number recorded on the form should be the number at which the client can be reached. If this number is not the client's own number, the assessor should note this (e.g., neighbor's number). Assessors should refer to the list of codes in Appendix L to get city/county codes. There is space after this question to record directions to the client's home and the presence of pets. It is important to be as specific as possible when recording directions.

Demographics (UAI, Page 1)

Record the client's date of birth (month, day and year), age and gender.

Marital Status (UAI, Page 1)

Choose the answer that best describes the client's current status relative to the civil rite or legal status of marriage.

- **Married** includes those who have been married only once and have never been widowed or divorced, as well as those currently married persons who remarried after having been widowed or divorced.

- **Widowed** includes clients, whether female or male, whose most recent spouse has died.

- **Separated** includes persons legally separated, living apart, or deserted.

- **Divorced** includes those whose most recent marriage has been dissolved by decree of a court of competent jurisdiction.

- **Single** includes persons who have never married, who have had their only marriage annulled and who claim a common law marriage, which is not recognized as a legal status in the Commonwealth of Virginia.

Race (UAI, Page 1)

Information about race is important for both epidemiological reasons and for comparisons with the population characteristics for the area served. Issues of accessibility, appropriateness of service and equity can be examined. The concept of race reflects self-identification and self-classification by the client according to the race with which he identifies. A suggested question is "Would you say that you are . . ." at which point the assessor reads the race categories. For persons who cannot provide a single response to the race question, use the first race reported by the person. In the space provided for Ethnic Origin, assessors may wish to record more specific information on a client's ethnicity, especially if this affects service eligibility and delivery. It should also be used to record Hispanic Origin, such as Mexican, Puerto Rican, Cuban, Central American or South American.

- **White** refers to any person having origins in any of the original peoples of Europe, North Africa or the Middle East. This category includes, but is not limited to, respondents who identify themselves as White, Canadian, German, Italian, Lebanese or Polish.

- **Black/African American** includes, but is not limited to, respondents who identify themselves as Black, African American, Afro-American, Negro, Jamaican, Black Puerto Rican, West Indian, Haitian or Nigerian.

- **American Indian** includes, but is not limited to, respondents who identify themselves as part of an Indian tribe, Canadian Indian, French-American Indian or Spanish-American Indian.

- **Oriental/Asian** includes, but is not limited to, respondents who identify themselves as Japanese, Chinese, Filipino, Korean, Vietnamese, Asian Indian, Hawaiian, Guamanian, Samoan, Cambodian, Laotian and Fiji Islander.

- **Alaskan Native** refers to a person having origins in any of the original people of Alaska.

Education (UAI, Page 1)

Education means the highest level of schooling attained by the client.

- **Less than High School** means some schooling at the elementary/middle school level or less.

- **Some High School** means education at the secondary level without attaining a high school diploma.

- **High School Graduate** means a high school diploma or equivalency certificate was received.

- **Some College** means education at an institution of higher learning without attaining a baccalaureate or associate degree.

- **College Graduate** means a baccalaureate or associate degree was received.

Space is provided to specify the level and/or type of education (i.e., special education, trade school, post-graduate work).

Communication of Needs (UAI, Page 1)

Communication of needs is the client's ability to express his or her requests, needs, opinions, problems and social concerns (whether in speech, in writing, in sign language, or a combination of methods) in a way that is readily and clearly understood. It is important to evaluate the client's ability to communicate with the provider(s) of care.

- **Verbally, English** means the client expresses himself or herself effectively through the use of the English language.

- **Verbally, Other Language** means the client makes himself or herself understood effectively through the use of a language other than English. Specify the other language.

- **Sign Language/Gestures/Device** means the client expresses himself or herself by pointing, using sign language, using a communication board, and/or through written or electronic means. This category includes clients who communicate in a language other than English which is not understood by the provider of care, but whose gestures or written symbols are understood. Circle how the client makes himself or herself understood and describe as needed.

- **Does Not Communicate** means the client does not convey information about his needs either verbally or non-verbally (e.g., comatose clients do not communicate their needs).

Space is provided to record whether the client is hearing impaired. If clients do not speak English and/or have hearing problems, it may be necessary to make alternative arrangements, such as using an interpreter, for effective communication while completing the full assessment.

Primary Caregiver/Emergency Contact/Primary Physician (UAI, Page 1)

Record the name, address, relationship and phone numbers (home and work) of caregivers mentioned by the client. These may include formal and informal caregivers. The first person listed should be the primary caregiver, emergency contact or the person who helps the most. If there is another helper or an emergency contact, record this person on the second line. Use the space for Relationship to record the person's relationship to the client and whether the person is the primary caregiver, emergency contact or both. Inform the client that it is necessary to have this information in the event that you are unable to reach the client or if there is an emergency or crisis that requires immediate attention.

Record the name (first and last), phone number and address of the client's primary physician. The primary physician is the doctor the person sees most often, the doctor who manages the person's overall medical care, or the doctor who would be called in case of an emergency.

Initial Contact (UAI, Page 1)

Record the name, relation and phone number of the person making the initial contact or call. This person may actually be the client. If the person making the contact is from an agency, the relation to the client would be "professional." In these cases, the individual at the referral agency should be contacted for a follow-up on the referral disposition. If the person calling asks to remain anonymous, write in "anonymous." This information will become part of the client's file and, as such, will be accessible to the client and others involved in assisting the client.

- **Presenting Problem/Diagnosis.** Record the reason for the contact/call and, if applicable, the client's medical diagnosis. It is important to record the presenting

problem as described by the caller and the length/duration of the problem(s) in order to know if the problem is a recent development or perceived to be a crisis.

Current Formal Services (UAI, Page 2)

Formal services are those provided by an agency or organization and are usually paid services. Clients may not pay directly for the service, but if it is provided and/or organized by an agency or organization, it is considered formal. A list of services is provided, and the assessor should read the entire list to the client. It may also be necessary to describe some of the services to assist clients in determining what they receive. Record whether or not the client currently receives the service, the provider of each service (including complete name and phone number) and the frequency of the service. Days of the weeks and the time of day are also valuable information to include. Formal service definitions are found in Appendix C. When coding services, focus on the type of service rather than the label or name a particular agency might give the service, or the setting where the service is provided.

Financial Resources (UAI, Page 2)

Annual/Monthly Income (UAI, Page 2)

Questioning clients about their financial status can be difficult. If the client does not want to discuss income information, then inform him or her that this information is needed to determine the available programs and services for which the client may be eligible. These questions are general, and it may be necessary to ask additional, more detailed financial questions when actually planning services. Where possible, work with other providers (such as the local DSS eligibility worker) who may have already received this information from the client to avoid duplicative questions.

- **Family Income** is the total annual (or monthly) gross income for the family unit. Annual and monthly incomes are provided to help those who may know one amount but not the other. Also, clients may feel more comfortable saying their income is within a certain range rather than giving a specific amount.

- **Family Unit** is the basis for determining family income. A minor is a person who is less than 18 years of age whose parent(s) is/are responsible for his or her care. A single family unit may consist of:

  - a husband and wife with or without their minor dependents;
  - a single individual and his/her minor dependents; or
  - an individual with no minor dependents.

  When individuals reside with other persons who are not their spouses and their minors, each shall be considered a separate family unit.

Examples of *separate* family units include:

- Elderly person(s) are considered a separate family unit even when they live in the home of their adult children or a relative;
- A mother (18 and over) and her dependents although living with her parents or another relative;
- The child of an unemancipated minor who lives with her mother and grandparent/s;
- A minor placed in foster care;
- A minor living with a legal guardian is considered a separate family unit if the guardian does not have financial responsibility;
- Unrelated individuals living together or as co-habitating partners, and
- A husband and wife who are separated are considered separate family units when they are not living together or when they are living together and are not dependent on each other for financial support. This determination can generally be used for the provision of services, but may not be allowable for the determination of financial benefits.

Space is provided to record the number of people in the family unit. There is also space to record, as an option, the actual amount of the monthly income for the family unit.

Income Source(s) (UAI, Page 2)

Record all sources of income for the family unit. As an option, the assessor may wish to record the amount received from each income source.

- **Black Lung** is a disability trust fund administered by the Department of Labor. This federal compensation program is designed to aid coal workers who have been determined to suffer from pneumoconiosis (Black Lung). Benefit payments can also be made to dependents or survivors.

- **Pension** is a sum of money paid regularly as a retirement benefit from a job.

- **Social Security** includes Social Security pensions, survivors' benefits and permanent disability insurance payments made by the Social Security Administration.

- **SSI/SSDI** are payments made by Federal, State or local welfare agencies to low income persons who are aged (65 years old or over), blind or disabled.

- **VA Benefits** include Veterans Administration (VA) pensions and disability payments.

- **Wages/Salary** means wages, salary, commissions, bonuses, or tips for all jobs (before deduction for taxes, etc.) including sick leave pay.

- **Other** may include income from rental, interest from investments, unemployment compensation, regular assistance from family members and regular financial aid from private organizations and churches.

Legal Representatives (UAI, Page 2)

Check all legal representatives the client has, and record names in the space provided. If someone else has legal authority to make decisions regarding the client's care, it is essential for you to know this and to include this person in the client's service delivery or care plan development. It is also helpful to read or obtain a copy of the legal documents which describe the authority given to the representative.

- **Guardian.** Court-appointed individual who is responsible for the personal affairs of an incapacitated person, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, therapeutic treatment, and, if not inconsistent with an order of commitment, regarding the person's residence.

- **Conservator.** Court-appointed individual who is responsible for managing the estate and financial affairs of an incapacitated person.

- **Power of Attorney.** A Power of Attorney is a written authorization for one person to act on behalf of another person (called the principal) for whatever purposes are spelled out in the written document. The Power of Attorney automatically ends upon the mental incapacity of the principal unless the document specifically states that it continues to be valid even after the onset of mental incapacity.

- **Representative Payee**. A person or organization authorized by a government agency to receive and manage a government benefit for a person deemed incapable of managing his own benefit.

Benefits/Entitlements (UAI, Page 2)

Record all benefits/entitlements the client receives.

- **Auxiliary Grant** is financial assistance for certain needy, aged, blind or disabled persons in residential institutions whose income is insufficient to cover the cost of their care.

- **Food Stamps** is a federal program to supplement the food budgets of low-income households to help assure eligible persons receive a nutritionally adequate diet.

- **Fuel Assistance** helps eligible households with the costs of heating their homes.

- **General Relief** is a state/local program that offers limited financial assistance to persons who meet requirements set by each locality. Relief may include aid for persons who are ill or temporarily out of work, medical care for the indigent, burial of the indigent, and other emergency situations.

- **State and Local Hospitalization** is assistance to income resource eligible persons who need to be or have been hospitalized, received emergency room treatment or outpatient hospitalization services.

- **Subsidized Housing** includes rent reduction, rent subsidies, and the state tax credit program.

- **Tax Relief** refers to property tax relief provided by local jurisdictions.

Health Insurance (UAI, Page 2)

Health insurance benefits are the current resources available to the client, which may be used to cover the costs of health and related care. Record all types of insurance and the numbers.

- **Medicare** number is the social security account number or the health insurance (HI) benefits number issued to the client who has coverage under Title XVIII, Social Security Amendments of 1965.

- **Medicaid** number is the 12-digit benefit number assigned by the local department of social services to a client who has coverage under Title XIX, Social Security Amendments of 1965. For those who have applied for Medicaid and are awaiting a final decision on eligibility, mark "No" for Medicaid and "Yes" for **Pending.** For individuals who are on spend-down, mark "No" for Medicaid and write "Spend-Down" in the space next to Medicaid.

  Also record whether the client is a Qualified Medicare Beneficiary (QMB) or a Specified Low Income Medicare Beneficiary (SLMB). A client who is QMB or SLMB has a Medicaid number but is not eligible for the full range of Medicaid reimbursed services. A client who qualifies as a QMB is eligible for Medicaid to pay his Medicare premiums and Medicare co-insurance and deductibles only. A Specified Low-Income Medicare Beneficiary (SLMB) program could help clients who have Medicare Part A and have income too high to be eligible for regular Medicaid or as a QMB. A client who qualifies as a SLMB is eligible for Medicaid to pay his or her Medicare Part B premiums only.
  Recipients of QMB receive a Medicaid card, and the QMB status is clearly indicated. Recipients of SLMB do not receive a Medicaid card. Verification of SLMB Medicaid can be obtained by viewing the client's notification letter issued by the local department of social services or with a proper release of information requesting the information from the agency.

- **Other** refers to any public or private insurance coverage other than Medicare or Medicaid.

Physical Environment (UAI, Page 3)

Living Arrangement (UAI, Page 3)

Record the type of place in which, and the people with whom, the client is or has been residing. If the client will be moving to a permanent living arrangement that is different from the one from which he or she is being assessed, record the place where the individual will be permanently residing. For example, if the assessment takes place in a hospital, but the individual will be transferred to an adult care residence, record the adult care residence as the living arrangement, not the hospital. If the permanent residence has not yet been chosen, note this. The UAI should be updated with the correct information as soon as it is known. For individuals residing in Adult Care Residences, Adult Foster/Family Homes, Nursing Facilities, Mental Health/Mental Retardation Facilities or Other institutional settings, record the name of the place, the approximate date of admission, and the Medicaid provider number.

The Medicaid provider number is only available for Medicaid-enrolled providers. If the client's usual living arrangement is a facility that is Medicaid certified, it is necessary to obtain the number regardless of the client's payment status. This number can be obtained from the facility administrator. It will be necessary to explain that the number is needed for recording purposes.

- **House** refers to a private residence, including mobile homes. Specify whether this is owned or rented by the client. Ownership by the client means the client's name is on the deed. The "Other" category includes situations where the client lives in a house owned by family/friends and does not pay rent, or the client lives in a house for which he or she has lifetime rights, but does not pay rent.

- **Apartment** is a private residence, rented by the client or by another person.

- **Rented Room(s)** are rooms with or without board, such as motels, hotels, YMCA/YWCA, and private residences. Rented rooms may include a private bath, but the inclusion of a private kitchen for preparing meals would constitute an apartment and should be coded as such.

- **Adult Care Residence** means any licensed place, establishment, or institution, public or private, operated or maintained for the maintenance or care of 4 or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting.

- **Adult Foster Care** is a small group home setting for 3 or fewer residents needing care.

- **Nursing Facility** refers to a nursing home licensed by the Department of Health.

- **Mental Health/Mental Retardation Facility** is a MH/MR residential or institutional facility licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

- **Other** may include transients who are living in a shelter and/or those who are homeless.

If the place of residence is house, apartment or rented rooms, the assessor must record with whom the client lives. Individual names of persons with whom the client lives are not necessary, but the relationship with the client should be noted.

- **Alone means** no one else lives with the client.

- **Spouse** means the only person living with the client is his spouse.

- **Other** includes clients who live with the spouse and children; clients who live with relatives other than the spouse and/or children, clients who live with non-relatives, and any combination of these.

Space is provided to record names of persons in the household. Assessors may also wish to record ages and relationships of these persons in order to evaluate current/potential sources of informal care.

Problems (UAI, Page 3)

Improvements in the physical condition of the client's place of residence can be cost-effective in the long run because they help sustain autonomous functioning and decrease dependence. Based on observation and the client's opinion, the assessor should evaluate the safety, security and support of the environment. Indicate the specific areas in which actual or potential safety or accessibility problems exist by placing a check in the "yes" column next to the relevant item. If it is not a problem, check "no." Do not leave blank. It is important to assess physical environment in terms of the client's particular situation. For example, look for visual smoke alarms for the hearing impaired. Use the space provided to record details about the problem. For example, if the problem is unsanitary conditions, specify if there is insect and/or rodent infestation.

- **Barriers to Access** includes features which make the living arrangement inaccessible to the client. For example, a client cannot use stairs and lives in a building with no elevator; the client cannot use stairs and lives in a 2-story home and

the bedrooms are upstairs; the client is in a wheelchair and the entrance has no ramp, or doorways are too narrow and rooms are too small to maneuver.

- **Electrical Hazards** include frayed electrical cords; over-use of extension cords; plugs partially hanging out of the wall, or poor wiring in the home.

- **Fire Hazards/No Smoke Alarm** includes wall-to-wall clutter; the client is a smoker and appears to be careless; the client forgets to turn off the stove; or there are no smoke alarms or an un-vented space heater is used.

- **Insufficient Heat/Air Conditioning** means the temperature is too hot or cold inside the client's home, or the room is stuffy during summer months.

- **Insufficient Hot Water/Water** could be indicated by an excessive amount of dirty dishes from lack of water; a client who is dirty and has unpleasant body odor, or a client who is wearing dirty clothing.

- **Lack of/Poor Toilet Facilities** means the client has no toilet facilities or toilet facilities exist but are in poor working condition. Specify whether the problem refers to toilet facilities inside or outside the home.

- **Lack of/Defective Stove, Refrigerator, Freezer** means the client either has no stove, refrigerator, or freezer, or the appliances exist but are in poor working condition.

- **Lack of/Defective Washer/Dryer** means the client either has no washer or dryer, or they exist but are in poor working condition.

- **Lack of/Poor Bathing Facilities** means the client either has no bathing facilities or bathing facilities exist but are sub-standard.

- **Structural Problems** include ceilings that have water leaks, dangerous floors, doors that open with difficulty, windows that cannot be opened, or an outside structure that looks crooked.

- **Telephone Not Accessible** means the client has no telephone and cannot access one from a neighbor or friend.

- **Unsafe Neighborhood** means the client lives in an area which is unsafe with frequent crime problems.

- **Unsafe/Poor Lighting** includes situations where the home is dark even with the lights on, or there is no or poor lighting outside the house.

- **Unsanitary Conditions** means there is any one or more of the following: an obvious odor in the home, the home is excessively dirty, there is a dirty and odorous bathroom, there is evidence of rodent and/or insect infestation, and/or carpet or furniture are soiled.

- **Other** means any other physical environment problems not categorized above.

SECTION II OF THE UAI: FUNCTIONAL STATUS

Measurements of functional status are commonly used across the country as a basis for differentiating among levels of long-term care giving. Functional status is the degree of independence with which an individual performs Activities of Daily Living (ADLs), Ambulation, and Instrumental Activities of Daily Living (IADLs).

ADLs indicate the client's ability to perform daily personal care tasks. The ADLs include:

- Bathing
- Dressing
- Toileting
- Transferring
- Eating/FeedingBowel and Bladder Control (Continence)

Ambulation is the client's ability to get around indoors and outdoors, climb stairs and wheel.

IADLs indicate the client's ability to perform certain social tasks that are not necessarily done every day but which are critical to living independently. The IADLs include:

- Meal Preparation
- Housekeeping
- Laundry
- Money Management
- Transportation
- Shopping
- Using the Telephone
- Doing Home Maintenance

There are three important points to remember when assessing functional status:

- **First,** functional status is a measure of the client's impairment level **and** need for personal assistance. Sometimes, impairment level and need for personal assistance are described by the help received, but this could lead be misleading. For example, a disabled client **needs** help to perform an activity in a safe manner, but he lives alone, has no formal supports and "receives no help." Coding the client's performance as "independent" because no help is received is very misleading in terms of the actual impairment level. In order to avoid this type of distortion, *interpret the ADLs in terms of what is usually needed to safely perform the entire activity.*

- **Second,** an assessment of functional status is based on what the client is **able** to do, not what he prefers to do. In other words, assess the client's *ability* to do particular activities, even if he doesn't usually do the activity. Lack of capacity should be distinguished from lack of motivation, opportunity, choice, or for the convenience of a caregiver. This is particularly relevant for the IADLs. For example, when asking someone if he can prepare light meals, the response may be "no" he or she does not prepare meals, even though he or she may be able to do so. This person should be coded as not needing help. If a client refuses to perform an activity, thus putting himself or herself at risk, it is important to probe for the reason why the client refuses in order to code the activity correctly. *The emphasis in this section is on assessing whether ability is impaired.* Physical health, mental health, or cognitive or

functional disability problems may manifest themselves as the inability to perform ADL, ambulation, and IADL activities. *If a person is mentally and physically free of impairment, there is no safety risk to the individual, and the person chooses not to complete an activity due to personal preference or choice, indicate that the person does not need help.*

- **Third,** the emphasis of the measurement of each of the functional activities should be *how the individual usually performed the activity over the past two weeks.* For example, if a client *usually* bathes himself or herself with no help, but on the date of the interview requires some assistance with bathing, code the client as requiring no help unless the client's ability to function on the date of the assessment accurately reflects ongoing need.

The functional status section is designed so that general information can be collected during the short assessment (screen) and more detailed information can be collected later. For example, during a screen the client may indicate that he or she needs help with bathing. The screener would check "Yes" under the Needs Help column. When the full assessment is completed with the client, the assessor would verify the accuracy of the answer and code the specific type of help needed in the box to the right (including the "Is Not Performed" category).

There are several components to each functional activity, and the coded response is based on the client's ability to perform **all** of the components. For example, when assessing the client's ability to bathe, it is necessary to ask about his or her ability to do all of the bathing activities such as getting in and out of the tub, preparing the bath, washing and towel drying. Interviewers will therefore need to probe in detail in order to establish actual functional level. ***The definitions of each ADL and other functional activities that follow should serve as a guide when probing for additional information.*** Self-reporting on ADLs and other functional activities should be verified by observation or reports of others. This is especially critical when clients report that they do activities by themselves, but the performance level or safety of the client is in question.

Some questions in this section are personal and the client may feel somewhat embarrassed to answer (e.g., toileting, bladder and bowel control). Ask these questions in a straightforward manner and without hesitation. If you ask the questions without embarrassment or hesitation, the client will be more likely to feel comfortable. If the client is embarrassed, acknowledge that some of these questions are embarrassing to answer. Let the client know that answers to these questions are important because they will help you better understand his or her needs and provide a service delivery or care plan that is right for him or her.

There is space at the end of the Functional Status section to record comments. Use this space to comment on functioning in the areas of ADLs, Ambulation, and IADLs. Comments should include the type of equipment used/needed to perform the activity and/or information about caregivers.

☞ **Because each item in the functional status section is critical to determining level of care needs, every functional question in this section must have a valid answer. If "yes" is checked in the "Needs Help?" column, the type of help must be indicated in the scoring options. No "Unknown" responses are allowed.**

In the Functional Status Section, capital "D's" (big D's) are placed on the UAI to denote dependence in a particular function. Dependence in functional status is used to differentiate among levels of long-term care.

The total number of "D's" or dependencies a client has will determine the type of care appropriate to meet his or her needs. Dependence includes a continuum of assistance, which ranges from minimal to total.

"Mechanical help only" means an individual is **semi-dependent (d)** in a functional area.

Dependence (D) means an individual needs at least the assistance of another person (human help only) **OR** needs at least the assistance of another person *and* equipment or a device (mechanical help and human help) to safely complete the activity. Human assistance includes supervision (verbal cues, prompting) or physical assistance (set-up, hands-on-care).

A client would be considered **totally dependent (DD)** in each level of functioning when the client is entirely unable to participate or assist in the activity performed.

Levels of Functioning (UAI, Page 4)

The general description for the scoring options are provided below. The definitions and/or scoring options for each ADL, ambulation, and IADLs are specifically defined and must be used to obtain an accurate assessment of each of the functional activities. Only ONE check mark can be made for each question. If more than one option applies, record the most dependent option.

- **Needs Help** means whether or not the client needs help (equipment or human assistance) to perform the activity. If the client does need help, score the specific type of help in the boxes to the right.

- **Mechanical Help Only** means the client needs equipment or a device to complete the activity, but does not need assistance from another human. Mechanical Help Only is not a dependency ("D"). **(d = semi-dependent)**

- **Human Help Only** means the client needs help from another person but does not need to use equipment in order to perform the activity. A need for human help exists when the client is unable to complete an activity due to cognitive impairment, functional disability, physical health problems, or safety. An unsafe situation exists when there is a negative consequence from not having help (e.g., falls, weight loss, skin breakdown), or there is the potential for a negative consequence to occur within the next 3 months without additional help. The decision that potential exists is based on some present condition such as a situation where the individual has never fallen when transferring but shakes or has difficulty completing the activity. *The assessor should not assume that any person over 60 and without help has the potential for negative consequences.* Within the human help category, specify whether the assistance needed is supervision or physical assistance. If both supervision and physical assistance are required, the category that should be used is the one reflecting the greatest degree of need, physical assistance. **(D=Dependent)**

  - **Supervision (Verbal Cues, Prompting).** The client is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him or her to safely perform the complete activity. This code often pertains to people with cognitive impairment, but may include those who need supervision for other reasons.

  - **Physical Assistance (Set-Up, Hands-On Care)**. Physical assistance means hands-on help by another human, including assistance with set-up of the activity.

- **Mechanical Help and Human Help** means the client needs equipment or a device *and* the assistance of another person to complete the activity. For this category, specify whether human help is supervision or physical assistance as defined above. **(D=Dependent)**

- **Performed by Others** means another person completes the entire activity and the client does not participate in the activity at all. **(DD=Dependent/Totally Dependent)**

- **Is Not Performed** means that neither the client nor another person performs the activity. **(DD=Dependent/Totally Dependent)**

Activities of Daily Living (UAI, page 4)

Bathing

Bathing: Getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying. Some clients may report various methods of bathing that constitute their usual pattern. For example, they may bathe themselves at a sink or basin five days a week, but take a tub bath two days of the week when an aide assists them. The questions refer to the method used **most or all of the time** to bathe the entire body.

- **Does Not Need Help.** Client gets in and out of the tub or shower, turns on the water, bathes entire body, or takes a full sponge bath at the sink and does not require immersion bathing, without using equipment or the assistance of any other person. **(I = Independent)**

- **Mechanical Help Only.** Client usually needs equipment or a device such as a shower/tub chair/stool, grab bars, pedal/knee controlled faucet, long-handled brush, and/or a mechanical lift to complete the bathing process. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client needs prompting and/or verbal cues to safely complete washing the entire body. This includes clients who need someone to teach them how to bathe.

  - **Physical Assistance (Set-up, Hands-On Care).** Someone fills the tub or brings water to the client, washes part of the body, helps the client get in and out of the tub or shower, and/or helps the client towel dry. Clients who only need human help to wash their backs or feet would not be included in this category. Such clients would be coded as "Does Not Need Help".

- **Mechanical and Human Help.** Client usually needs equipment or a device *and* requires assistance of other(s) to bathe. **(D=Dependent)**

- **Performed by Others**. Client is completely bathed by other(s) and does not take part in the activity at all. **(DD=Dependent/Totally Dependent)**

Dressing

Dressing: Getting clothes from closets and/or drawers, putting them on, fastening and taking them off. Clothing refers to clothes, braces and artificial limbs worn daily. Clients who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

- **Does Not Need Help.** Client usually completes the dressing process without help from others. If the only help someone gets is tying shoes, do not count as needing help. **(I = Independent)**

- **Mechanical Help Only**. Client usually needs equipment or a device such as a long-handled shoehorn, zipper pulls, specially designed clothing or a walker with an attached basket to complete the dressing process. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client usually requires prompting and/or verbal cues to complete the dressing process. This category also includes clients who are being taught to dress.

  - **Physical Assistance (Set-up, Hands-On Care).** Client usually requires assistance from another person who helps in obtaining clothing, fastening hooks, putting on clothes or artificial limbs, etc.

- **Mechanical and Human Help.** Client usually needs equipment or a device and requires assistance of other(s) to dress. **(D=Dependent)**

- **Performed by Others**. Client is completely dressed by another individual and does not take part in the activity at all. **(DD=Dependent/Totally Dependent)**

- **Is Not Performed.** Refers only to bedfast clients who are considered not dressed. **(DD=Dependent/Totally Dependent)**

Toileting

Toileting: Ability to get to and from the bathroom, get on/off the toilet, clean oneself, manage clothes and flush. A commode at any site may be considered the "bathroom" only if in addition to meeting the criteria for "toileting" the client empties, cleanses, and replaces the receptacle, such as the bed pan, urinal or commode, without assistance from other(s).

- **Does Not Need Help.** Client uses the bathroom, cleans self, and arranges clothes without help. **(I = Independent)**

- **Mechanical Help Only**. Client needs grab bars, raised toilet seat or transfer board and manages these devices without the aid of other(s). Includes clients who use handrails, walkers, or canes for support to complete the toileting process. Also includes clients who use the bathroom without help during the day and use a bedpan, urinal, or bedside commode without help during the night and can empty this receptacle without assistance. **(d = semi-dependent)**

- **Human Help Only. (D=Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client requires verbal cues and/or prompting to complete the toileting process.

  - **Physical Assistance (Set-up, Hands-On Care).** Client usually requires assistance from another person who helps in getting to/from the bathroom, adjusting clothes, transferring on and off the toilet, or cleansing after elimination. The client participates in the activity.

- **Mechanical and Human Help.** Client usually needs equipment or a device *and* requires assistance of other(s) to toilet. **(D=Dependent)**

- **Performed by Others.** Client does use the bathroom, but is totally dependent on another's assistance. Client does **not** participate in the activity at all. **(DD=Dependent/Totally Dependent)**

- **Is Not Performed**. Client does not use the bathroom. **(DD=Dependent/Totally Dependent)**

Transferring

Transferring: Means the client's ability to move between the bed, chair, and/or wheelchair. If a person needs help with some transfers but not all, code assistance at the highest level.

- **Does Not Need Help.** Client usually completes the transferring process without human assistance or use of equipment. **(I = Independent)**

- **Mechanical Help Only**. Client usually needs equipment or a device, such as lifts, hospital beds, sliding boards, pulleys, trapezes, railings, walkers or the arm of a chair, to safely transfer, *and* client manages these devices without the aid of another person. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**

  - **Supervision (Verbal Cues, Prompting).** Client usually needs verbal cues or guarding to safely transfer.

  - **Physical Assistance (Set-up, Hands-On Care).** Client usually requires the assistance of another person who lifts some of the client's body weight and provides physical support in order for the client to safely transfer.

- **Mechanical and Human Help.** Client usually needs equipment or a device and requires the assistance of other(s) to transfer. **(D=Dependent)**

- **Performed By Others.** Client is usually lifted out of the bed and/or chair by another person and does not participate in the process. If the client does not bear weight on any body part in the transferring process he/she is not participating in the transfer. Clients who are transferred with a mechanical or Hoyer lift are included in this category. **(DD=Dependent/Totally Dependent)**

- **Is Not Performed.** The client is confined to the bed. **(DD=Dependent/Totally Dependent)**

Eating/Feeding

Eating/Feeding: The process of getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the client's mouth, opening a carton and pouring liquids, and holding a glass to drink. This activity is the process of eating food after it is placed in front of the client.

- **Does Not Need Help**. Client is able to perform all of the activities without using equipment or the supervision or assistance of another. **(I = Independent)**

- **Mechanical Help Only**. Client usually needs equipment or a device, such as hand splints, adapted utensils, and/or nonskid plates, in order to complete the eating process. Clients needing mechanically adjusted diets (pureed food) and/or food chopped are included in this category. **(d = semi-dependent)**

- **Human Help Only (D=Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client feeds self, but needs verbal cues and/or prompting to initiate and/or complete the eating process.

  - **Physical Assistance (Set-up, Hands-On Care)**. Client needs assistance to bring food to the mouth, cut meat, butter bread, open cartons and/or pour liquid due to an actual physical or mental disability (e.g., severe arthritis, Alzheimer's). This category must **not** be checked if the client is able to feed himself but it is more convenient for the caregiver to complete the activity.

- **Mechanical and Human Help.** Client usually needs equipment or a device and requires assistance of other(s) to eat. **(D=Dependent)**

- **Performed By Others.** Includes clients who are spoon fed; fed by syringe or tube, or clients who are fed intravenously (IV). *Spoon fed* means the client does not bring any food to his mouth and is fed completely by others. *Fed by syringe or tube* means the client usually is fed a prescribed liquid diet via a feeding syringe, NG-tube (tube from the nose to the stomach) or G-tube (opening into the stomach). *Fed by I.V.* means the client usually is fed a prescribed sterile solution intravenously. **(DD=Dependent/Totally Dependent)**

Continence (UAI, page 4)

Continence is the ability to control urination (bladder) and elimination (bowel). Incontinence may have one of several different causes, including specific disease processes and side effects of medications. Helpful questions include, "Do you get to the bathroom on time?"; "How often do you have accidents?"; and "Do you use pads or adult diapers?"

Bowel Continence

Bowel: The physiological process of elimination of feces.

- **Does Not Need Help.** The client voluntarily controls the elimination of feces. If the client on a bowel program never empties his or her bladder without stimulation or a specified bowel regimen, he or she is coded as "Does not need help," and the bowel/bladder training is noted under medical/nursing needs. In this case, there is no voluntary elimination; evacuation is planned. If a client on a bowel regimen also has occasions of bowel incontinence, then he or she would be coded as incontinent, either less than weekly or weekly or more. **(I = Independent)**

- **Incontinent Less Than Weekly.** The client has involuntary elimination of feces less than weekly (e.g., every other week). **(d = semi-dependent)**

- **Ostomy - Self Care.** The client has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and he completely cares for the ostomy, stoma, and skin cleansing, dressing, application of appliance, irrigation, etc. *Clients who use pads or adult diapers and correctly dispose of them should be coded here.* **(d = semi-dependent)**

- **Incontinent Weekly or More.** The client has involuntary elimination of feces at least once a week. *Clients who use pads or adult diapers and do not correctly dispose of them should be coded here.* **(D=Dependent)**

- **Ostomy - Not Self Care.** The client has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and another person cares for the ostomy: stoma and skin cleansing, dressing, application of appliance, irrigations, etc. **(DD=Dependent/Totally Dependent)**

Bladder Continence

Bladder: The physiological process of elimination of urine.

- **Does Not Need Help**. The client voluntarily empties his or her bladder. Clients on dialysis who have no urine output would be coded "Does not need help" as he or she does not perform this process. Dialysis will be noted under medical/nursing needs. Similarly, individuals who perform the Crede method for himself or herself for bladder elimination would also be coded "Does not need help." **(I = Independent)**

- **Incontinent Less Than Weekly.** The client has involuntary emptying or loss of urine less than weekly. **(d = semi-dependent)**

- **External Device, Indwelling Catheter, or Ostomy - Self Care.** The client has an urosheath or condom with a receptacle attached to collect urine (external catheter); a hollow cylinder passed through the urethra into the bladder (internal catheter) or a surgical procedure that establishes an external opening into the ureter(s) (ostomy). The client completely cares for urinary devices (changes the catheter or external device, irrigates as needed, empties and replaces the receptacle) and the skin surrounding the ostomy. *Clients who use pads or adult diapers and correctly dispose of them should be coded here.* **(d = semi-dependent)**

- **Incontinent Weekly or More.** The client has involuntary emptying or loss of urine at least once a week. *Clients who use pads or adult diapers and do not correctly dispose of them should be coded here.* **(D=Dependent)**

- **External Device - Not Self Care.** Client has an urosheath or condom with a receptacle attached to collect urine. Another person cares for the client's external device. **(DD=Dependent/Totally Dependent)**

- **Indwelling Catheter - Not Self Care.** Client has a hollow cylinder passed through the urethra into the bladder. Another person cares for the client's indwelling catheter. This category includes clients who self-catheterize, but who need assistance to set-up, clean up, etc. **(DD=Dependent/Totally Dependent)**

- **Ostomy - Not Self Care.** Client has a surgical procedure that establishes an external opening into the ureter(s). Another person cares for the client's ostomy. **(DD=Dependent/Totally Dependent)**

Ambulation (UAI, Page 4)

Ambulation is the ability to get around indoors (walking) and outdoors (mobility), climb stairs and wheel. Clients who are confined to a bed or chair must be shown as needing help for all ambulation activities. This is necessary in order to show their level of functioning/dependence in ambulation accurately. Clients who are confined to a bed or a chair are coded **Is Not Performed** for all ambulation activities. Specific information for each ambulation activity is given below.

Walking

Walking: The process of moving about indoors on foot or on artificial limbs.

- **Does Not Need Help**. Client usually walks steadily more than a few steps without the help of another person or the use of equipment. Do not code here clients confined to a bed or a chair. **(I = Independent)**

- **Mechanical Help Only**. Client usually needs equipment or a device to walk. Equipment or device includes splints, braces, crutches, special shoes, canes, walkers, handrails and/or furniture. **(d = semi-dependent)**

- **Human Help Only (D = Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client usually requires the assistance of another person who provides verbal cues or prompting.

  - **Physical Assistance (Set-up, Hands-On Care)**. Client usually requires assistance of another person who provides physical support, guarding, guiding or protection.

- **Mechanical and Human Help.** Client usually needs equipment or a device *and* requires assistance of other(s) to walk. **(D = Dependent)**

- **Is Not Performed.** The client does not usually walk. Clients who are bedfast would be coded here. The client may be able to take a few steps from bed to chair with support, but this alone does not constitute walking and should be coded as **Is Not Performed**. **(D = Dependent)**

Wheeling

Wheeling: The process of moving about by a wheelchair. The wheelchair itself is not considered a mechanical device for this assessment section.

- **Does Not Need Help**. The client usually does not use a wheelchair, or the client uses a wheelchair and independently propels it. *Do not code here clients confined to a bed or chair*. **(I = Independent)**

- **Mechanical Help Only**. Client usually needs a wheelchair equipped with an adaptation(s) such as an electric chair, amputee chair, one-arm drive, or removable armchair. **(d = semi-dependent)**

- **Human Help Only (D = Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client usually needs a wheelchair and requires the assistance of another person who provides prompting or cues.

  - **Physical Assistance (Set-up, Hands-On Care)**. Client usually needs a wheelchair and requires assistance of another person to wheel.

- **Mechanical and Human Help.** Client usually needs an *adapted* wheelchair *and* requires assistance of other(s) to wheel. **(D = Dependent)**

- **Performed By Others.** Client is transported in a wheelchair and does not propel or guide it. The client may wheel a few feet within his own room or within an activity area, but this alone does not constitute wheeling. **(D = Dependent)**

- **Is Not Performed.** The client is confined to a chair or a wheelchair that is not moved, or the client is bedfast. This does not include clients who usually do not use a wheelchair to move about. **(D = Dependent)**

Stair Climbing

Stair Climbing: The process of climbing up and down a flight of stairs from one floor to another. *If the client does not live in a dwelling unit with stairs, ask whether he can climb stairs if necessary.*

- **Does Not Need Help**. Client usually climbs up and down a flight of stairs without difficulty on his own. Do not code here clients confined to a bed or a chair. **(I = Independent)**

- **Mechanical Help Only**. Client usually needs equipment or a device to climb stairs. Equipment or device includes splints, special shoes, leg braces, crutches, canes, walkers and special hand railings. Regular hand railings are considered equipment if the person is dependent upon them to go up or down the stairs. **(d = semi-dependent)**

- **Human Help Only (D = Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client usually requires assistance, such as guiding and protecting, from another person.

  - **Physical Assistance (Set-up, Hands-On Care)**. Client usually requires assistance from another person who physically supports the client climbing up or down the stairs.

- **Mechanical and Human Help.** Client usually needs equipment or a device *and* requires assistance of other(s) to climb stairs. **(D = Dependent)**

- **Is Not Performed.** The client is unable to climb a flight of stairs due to mental or physical disabilities. **(D = Dependent)**

Mobility

Mobility: The extent of the client's movement outside his or her usual living quarters. Evaluate the client's ability to walk steadily and his or her level of endurance.

- **Does Not Need Help**. Client usually goes outside of his or her residence on a routine basis. If the only time the client goes outside is for trips to medical appointments or treatments by ambulance, car, or van, do not code the client here because this is not considered going outside. These clients would be coded either in the "confined - moves about" or "confined - does not move about" categories. **(I = Independent)**

- **Mechanical Help Only**. Client usually needs equipment or a device to go outside. Equipment or device includes splint, special shoes, leg braces, crutches, walkers, wheelchairs, canes, handrails, chairlifts, and special ramps. **(d = semi-dependent)**
- **Human Help Only (D = Dependent)**

  - **Supervision (Verbal Cues, Prompting)**. Client usually requires assistance from another person who provides supervision, cues, or coaxing to go outside.

  - **Physical Assistance (Set-up, Hands-On Care)**. Client usually receives assistance from another person who physically supports or steadies the client to go outside.

- **Mechanical and Human Help**. Client usually needs equipment or a device and requires assistance of other(s) to go outside. **(D = Dependent)**

- **Confined - Moves About**. Client does not customarily go outside of his or her residence, but does go outside of his or her room. **(D = Dependent)**

- **Confined - Does Not Move About**. The client usually stays in his or her room. **(D = Dependent)**

Instrumental Activities of Daily Living (UAI, Page 4)

IADLs are more complex than activities related to personal self-care. Personal motivation may play a very important role in a person's ability to perform IADLs. For example, a depressed person may neglect activities such as cooking and cleaning. IADLs may also measure a person's social situation and environment rather than ability level. For example, the inability to cook, for one who has never cooked, does not necessarily reflect impaired capacity. In both of these situations, the assessor should probe to get information about the type of help needed to do the activity.

Level of Functioning

- **Does Not Need Help** means the client does not require personal assistance from another to complete the entire activity in a safe manner. Clients who need equipment, but receive no personal assistance, are included in this category. **(I = Independent)**

- **Does Need Help** means the client needs personal assistance, including supervision, cueing, prompts, set-up and/or hands-on help to complete the entire activity in a safe manner. **(D = Dependent)**

Activities

- **Meal Preparation:** The ability to plan, prepare, cook, and serve food. If it is necessary for someone to bring meals to the client, which he or she reheats, this is considered needing help.

- **Housekeeping:** The ability to do light housework such as dusting, washing dishes, making the bed, vacuuming, cleaning floors, and cleaning the kitchen and bathroom.

- **Laundry** (washing and drying clothes): This includes putting clothes in and taking them out of the washer/dryer and/or hanging clothes on and removing them from a clothesline, and ironing, folding, and putting clothes away. If the client lives with others and does not do his or her own laundry, be sure to ask whether he or she could do laundry.

- **Money Management:** This does not refer to handling complicated investments or taxes. It refers to the client's ability to manage day-to-day financial matters such as paying bills, writing checks, handling cash transactions, and making change.

- **Transportation**: The ability to use transportation as well as access to transportation. It includes the ability to either transport oneself or arrange for transportation, to get to and from, and in and out of the vehicle (i.e., a car, taxi, bus, or van). It is

important to make note of the client's main source of transportation, especially for those who rely on public services.

- **Shopping**: The ability to get to and from the store, obtain groceries and other necessary items such as clothing, toiletries, household goods and supplies, pay for them, and carry them home. Not having access to transportation does not make the person dependent in shopping. It is important to determine whether the client would be *able* to shop by himself, regardless of whether he or she currently has help with shopping.

- **Using the Telephone**: The client's ability to look up telephone numbers, dial, hear, speak on, and answer the telephone. If the client has no telephone, ask about the ability to use a telephone somewhere else.

- **Home Maintenance:** The ability to do activities such as yard work, making minor repairs, carrying out the trash and washing windows. These activities are less frequent than housework activities.

This concludes the short component (screen) of the assessment. If you are continuing with the full assessment, mark the first response. If only the short assessment is planned at this time, specify whether service referrals will or will not be made. In the last two spaces, record the name and agency of the person completing the short assessment. It is helpful to record the assessor's telephone number.

SECTION III OF THE UAI: PHYSICAL HEALTH ASSESSMENT

The physical health assessment is multi-dimensional and looks at the use of medical services, diagnoses, medication profiles, sensory functions, physical status, nutrition, and ongoing medical/nursing needs. Understanding medical conditions frequently present in the frail, older person is essential to determining whether a condition is "life threatening" or interferes with Activities of Daily Living.

Professional Visits/Medical Admissions (UAI, Page 5)

Doctors' Names (UAI, Page 5)
Record the names of all doctors the client *currently* sees. This includes psychiatrists or other physicians seen for emotional or mental health reasons. In the spaces provided, list each doctor's phone number, and the date and reason for the last visit to the doctor. The exact date of the last visit is not needed; an approximate date, such as "11/98," will suffice.

Admissions (UAI, Page 5)
Record any admissions to hospitals, nursing facilities, or adult care residences in the *past 12 months* for medical or rehabilitation reasons. Record the name of the place, the admission date, and the length of stay, and reason for the admission. The exact date of the admission is not needed; an approximate date, such as "11/98," will suffice. If there have been multiple hospital, nursing facility, or adult care residence admissions in the past 12 months, only record the most recent one in the space provided. Other admissions can be recorded in the blank space below this question or in the Comment section. Do not include admissions for emotional or nervous problems here; these are documented in the Psycho-Social Assessment section, page 10. Emergency room visits are not considered admissions; dates of emergency room visits should be recorded in the Comments Section.

Advance Directives (UAI, Page 5)
The Virginia Advance Medical Directive has three components: the Living Will, the Durable Power of Attorney for Health Care, and Appointment of Agent to Make Anatomical Gift. The Living Will and the Durable Power of Attorney for Health Care allow a client to name another person to make decisions on his behalf when death is inevitable, when the client is in a persistent vegetative state, or when the client is not dying but is unable to make his own decision. Use the space provided to record where any documents are located and/or who has the documents. Other advance directives might include prepaid funeral or burial funds, or in the case of an appointment of an agent to make an anatomical gift, they might include organ donation.

Diagnoses & Medication Profile (UAI, Page 5)

Diagnoses (UAI, Page 5)

Record all diseases and injuries, *as determined by a physician(s),* that are currently affecting the client. A suggested way to gather this information is to say, "Has a doctor told you that you have (review the list)?" The diagnoses include mental illness and mental retardation diagnoses. General information on diagnoses is provided in Appendix D. Record the name of each active diagnosis and the approximate date of onset. It is not necessary to record the exact date of onset. The objective is to get a sense of how long the problem has existed.

Use the list of diagnoses and codes to enter the codes for the three major, active diagnoses confirmed by a physician. If there are more than three major, active diagnoses, code the unstable and/or life threatening ones first. Any active diagnosis not listed should be given a code of "42." If the client currently has no active diagnoses, check "None." The intent of coding only diagnoses that are determined by a physician is to avoid coding ailments, complaints, etc. that have *not* been verified by a medical professional. However, information about ailments, complaints, and other problems is important and may indicate a need for follow-up and/or a medical evaluation. Assessors do not code this information, but should still note it in the blank area on this page or in the Comment Section of the assessment form.

Diagnosis	Code
Alcoholism/Substance Abuse	01
Blood-Related Problems	02
Cancer	03
Cardiovascular Problems	
Circulation Problems	04
Heart Trouble	05
High Blood Pressure	06
Other Cardiovascular Problems	07
Dementia	
Alzheimer's	08
Non-Alzheimer's Dementia	09
Developmental Disabilities	
Mental Retardation	10
Autism	11
Cerebral Palsy	12
Epilepsy	13
Friedreich's Ataxia	14
Multiple Sclerosis	15
Muscular Dystrophy	16
Spina Bifida	17
Digestive/Liver/Gall Bladder Problems	18
Endocrine (Gland) Problems	
Diabetes	19
Other Endocrine Problems	20
Eye Disorders	21
Immune System Disorders	22
Muscular/Skeletal	
Arthritis/Rheumatoid Arthritis	23
Osteoporosis	24
Other Muscular/Skeletal Problems	25
Neurological Problems	
Brain Trauma/Injury	26
Spinal Cord Injury	27
Stroke	28
Other Neurological Problems	29
Psychiatric Problems	
Anxiety Disorders	30
Bipolar Disorder	31
Major Depression	32
Personality Disorder	33
Schizophrenia	34
Other Psychiatric Problems	35
Respiratory Problems	
Black Lung	36
COPD	37
Pneumonia	38
Other Respiratory Problems	39
Urinary/Reproductive Problems	
Renal Failure	40
Other Urinary/Reproductive Problems	41
All Other Problems	42

Medications (UAI, Page 5)

List all medications, including prescription and over-the-counter (OTC), that the client *currently* takes. Prescribed medications include those to be taken regularly and those ordered to be taken as needed (PRN). OTC medications include vitamins, laxatives, antacids, etc. If possible, record the dose (amount), frequency (number of times per day the medication is taken), route of admission (i.e., by mouth, injection, inhalant, suppository) and reason prescribed. It is helpful to ask to see medication bottles in order to record the

information requested and to check the last refill date to confirm that necessary medication is currently being taken.

Record the total number of medications the client is *currently* taking. Although the history of medication use is important, only record the number of current medications. For clients taking multiple medications, it is important to find out about potential interactions between prescribed, over-the-counter, or both types of medications. A list of medications and their usual and customary use is found in Appendix N.

Of the total number, record how many are tranquilizers and/or psychotropic drugs. Psychotropic drugs include any substances that have an altering effect on the mind. A list of common psychotropic drugs, and their generic names, is included in Appendix E. This list is not inclusive, but can be used as a guide. Major psychiatric symptoms and disorders occur in 15-25 percent of persons aged 65 and older. Two-thirds of the elderly take 5-12 medications daily, and psychotropic drugs are the third most commonly prescribed medication among the elderly, surpassed only by cardiovascular drugs and analgesics (Cadieux, 1993).

> ☞ **If the client is not currently taking any medications, write in "0" for *Total Number of Medications,* answer the question *"Do you have any problems with medicines?"* and check *Without Assistance* for the question *"How do you take your medications?"* PLEASE IGNORE THE NOTE ON THE UAI THAT ASKS THE ASSESSOR TO "SKIP TO SENSORY FUNCTIONS."**

Problems with Medications (UAI, Page 5)

Record all problems related to either getting or taking medicine. These are not necessarily problems that have been confirmed/diagnosed by a physician. Problems with non-compliance would be coded as "Yes" for the category *Taking Them as Instructed/Prescribed.*

Taking Medications (UAI, Page 5)

Assess how the client takes his medicine. Focus on what is needed rather than what is happening. For example, a client who is able to take his or her medicine without any help, *but who uses help because it is available,* should be coded as *Without Assistance*. Likewise, a client who is taking his or her medication without any help, but who clearly needs help because he or she is not taking the medicine correctly, should be coded as one of the other methods of taking medications, as appropriate. For those needing some type of assistance taking medicine, use the space provided to record the type of help and the name of the helper. It is very important to record accurate information here because this question is critical to determining eligibility for some long-term care and aging services.

- **Without Assistance or No Medications** means the client takes medication without any assistance from another person or does not take any medications.

- **Administered/Monitored by lay person(s)** means the client needs assistance of a person without pharmacology training to either administer or monitor medications.

- **Administered/Monitored by Professional Nursing Staff** means the client needs licensed or professional health personnel to administer or monitor some or all of the medications.

Sensory Functions (UAI, Page 6)

Vision, Hearing, Speech (UAI, Page 6)

Sensory functions refer to sight, hearing and speech. Within each function, code for the greatest degree of impairment. If there is an impairment, mark whether or not there is compensation. If there is compensation, record the type/method. If there is no compensation, record the reason for the lack of compensation. Use the space in the box to also record the date of onset of the impairment and the type of impairment. In the last column, record the date of the client's last eye, ear and speech exam. It is not necessary to record exact dates. Approximate dates, such as "11/98," will suffice. Appendix J contains indicators to help decide whether to refer someone to the Virginia Department for the Visually Handicapped for a more specialized assessment.

- **No Impairment** means no loss of vision or hearing, or the client speaks with no impediment.

- **Impairment - Compensation** means seeing/hearing is restricted in one or both eyes/ears and compensation improves sight/hearing, or there are impairments to the normal production of speech and compensation improves speech. Compensation includes the effective use of devices such as glasses, hearing aids and communication boards.

- **Impairment - No Compensation** means seeing/hearing is restricted in one or both eyes/ears and either compensation does not improve sight/hearing or there is no compensation, or there are impairments to the normal production of speech and either compensation does not improve speech or there is no compensation.

- **Complete Loss** means the client has no vision/hearing abilities and/or has lost the ability to process language/produce speech.

Physical Status (UAI, Page 6)

Joint Motion (UAI, Page 6)

Assess the client's ability to move his or her fingers, arms and legs (active Range of Movement - ROM) or, if applicable, the ability of someone else to move the client's fingers, arms and legs (passive ROM). If necessary, the assessor may ask the client to demonstrate if he or she can raise his or her arms above his or her head or wiggle his or her fingers.

- **Within Normal Limits or Instability Corrected** means the joints can be moved to functional motion without restriction, *or* a joint does not maintain functional motion and/or position when pressure or stress is applied but has been corrected by the use of an appliance or by surgical procedure. **(I = Independent)**

- **Limited Motion** means partial restriction in the movement of a joint including any inflammatory process in the joint causing redness, pain and/or swelling that limits the motion of the joint. **(d = semi-dependent)**

- **Instability Uncorrected or Immobile** means a joint does not maintain functional motion and/or position when pressure or stress is applied and the disorder has not been surgically corrected or an appliance is not used, *or* there is total restriction in the movement of a joint (e.g., contractures, which are common in individuals who have had strokes). **(D = Dependent)**

Fractures/Dislocations (UAI, Page 6)

Record whether or not the client has *ever* fractured or dislocated bones. If no, check "None" and skip the next two questions in the column. If yes, record the type of fracture/dislocation, whether a rehabilitation program was completed and the approximate date the fracture/dislocation occurred.

- **Hip Fracture** is a break in the femur in the area of the hip.

- **Other Broken Bones** is a break in other bones of the body. This category includes compression fractures.

- **Dislocation** is the displacement or temporary removal of a bone from its normal position in the joint.

- **Combination** is a combination of broken bone(s), fractures and dislocation(s).

- **Previous Rehabilitation Program** refers to the completion of a planned therapy and/or other restorative program intended to improve or restore the client's functional use of the part of the body impaired by the dislocation or fracture.

- **Date** refers to how recently the fracture(s) or dislocation(s) occurred.

Missing Limbs (UAI, Page 6)
Record whether or not the client is missing all or part of an upper or lower extremity due to trauma, congenital malformation or surgical procedure. If no, check "None" and skip the next two questions in the column. If yes, record the type of missing limb, whether a rehabilitation program was completed, and the approximate date of the amputation.

- **Fingers or Toes** means the absence of one or more fingers and/or toes.

- **Arms** means the absence of some portion of the hand, lower arm, elbow, or upper arm to the shoulder joint.

- **Leg** means the absence of some portion of the foot, lower leg, or upper leg to the hip joint.

- **Combination** is any combination of missing limbs.

- **Previous Rehabilitation Program** refers to the completion of a planned program of therapy and/or other restorative program intended to improve or restore the client's ability to perform the functions of the missing body part.

- **Date** refers to how recently the loss of the missing limb occurred.

Paralysis/Paresis (UAI, Page 6)
Record whether or not the client has *ever* suffered from paralysis or paresis. **Paralysis** is the loss of voluntary motion of a part of the body with or without the loss of sensation. **Paresis** is partial or incomplete paralysis (i.e., weakness). If no, check "None" and skip the next two questions in the column. If the client has ever suffered from paralysis or paresis, record the type of paralysis/paresis, whether a rehabilitation program was completed, and the date of onset.

When recording the type of paralysis/paresis, use as much detail as possible. For example, note whether the client is:

- paraplegic (paralysis of the lower half of the body, including both legs);
- hemiplegic (paralysis of one side of the body, including both the arm and leg); or
- quadriplegic (paralysis of the body, including all four extremities).

Code paralysis/paresis as follows:

- **Partial Paralysis/Paresis** is the paralysis of a single extremity, part of an extremity, one half of the body, one side of the body and/or a combination of these.

- **Total Paralysis/Paresis** is the paralysis of both sides of the body or the entire body.

- **Previous Rehabilitation Program** refers to the completion of a planned therapy and/or other restorative program intended to improve or restore the client's functional use of the part of the body paralyzed.

- **Onset** refers to how recently the paralysis/paresis occurred.

Nutrition (UAI, Page 6)

Height/Weight (UAI, Page 6)

Record what the client reports to be his or her height (in inches) and weight (in pounds). If the client has undergone a bilateral amputation, record his or her height *prior* to the amputation. Record whether there has been recent weight gain and/or loss over 10%. If yes, provide details in the space provided (e.g., indicate whether recent weight change is gain or loss). This question is important because a 10% unintentional weight gain or loss may indicate a health problem.

If the individual is unable to report his or her weight, the assessor should consult with others who may have this information or use his or her professional judgment to estimate the individual's weight. Height and weight must be recorded.

Special Diet (UAI, Page 6)

Record whether the client is on a special diet, *as prescribed by his or her physician*.

- **Low Fat/Low Cholesterol** - Protein and carbohydrates are increased with a limited amount of fat in the diet. (This diet is often prescribed for clients with heart disease, gallbladder disease, disorders of fat digestion, and liver disease.)

- **No/Low Salt** - Either no salt or only a specific amount of sodium (salt) is allowed. (Low sodium diets are often ordered for clients with heart disease, high blood pressure, liver disease, or kidney disease.)

- **No/Low Sugar** - The amount of carbohydrates, starch, protein and fat, and the number of calories are regulated. (No/Low sugar diets are often ordered for clients with hypoglycemia, hyperglycemia and diabetes.)

- **Combination/Other** - Combination of low fat/cholesterol and no/low salt/sugar, or some other special diet. An example of a special diet is fluid restriction due to

kidney problems. Specify the type of combination/other special diet in the space provided.

Dietary Supplements (UAI, Page 6)
Record whether or not the client takes food or fluid in addition to regular meals to supplement nutritional intake (e.g., Ensure, Isocal, or Sustacal). Assessors should note whether dietary supplements are prescribed by a physician.

- **Occasionally** - Supplements are taken less than daily.

- **Daily, Not Primary Source** - Supplements are taken daily, but are not the primary source of nutrition. In other words, the client eats some food, but supplements are taken daily to add nutrients and/or calories.

- **Daily, Primary Source** - Client *may be unable* to take oral nutrition, or oral intake that can be tolerated is inadequate to maintain life. Supplements are taken daily and the focus is on maintenance of weight and strength. These clients may still eat other food. Equipment may be used to take the supplement(s).

- **Daily, Sole Source** - Client *is unable* to swallow or absorb any oral nutrition and equipment must be used (nasogastric tube (NG tube) or gastric tube (G-tube)). For these clients, the supplement is all they take.

Dietary Problems (UAI, Page 6)
Record all problems that make it difficult for the client to eat.

- **Food Allergies** refers to specific foods to which the client is allergic. It is important to distinguish between real food allergies and personal dislikes. The assessor should note the type of food allergy in the space available.

- **Inadequate Food/Fluid Intake** means the amount of food/fluid intake is not adequate for daily requirements.

- **Nausea/Vomiting/Diarrhea** which occurs before or after eating or another time of day.

- **Problems Eating Certain Foods** means certain foods cannot be eaten or must be eaten very carefully (e.g., small bites chewed thoroughly).

- **Problems Following Special Diets** means the client does not understand and/or follow the treatment plan resulting in health problems. One example is a diabetic who does not follow his or her diet plan.

- **Problems Swallowing** refers to structural problems with the esophagus (stricture, tumor, or cancer of the palate, mouth, or throat or result of a neurological condition such as a CVA or Parkinsons disease).

- **Taste Problems** means clients refuse foods because of an inability to taste or taste that is unacceptable.

- **Tooth or Mouth Problems** may include problems which make it difficult to chew. Note dental problems, such as decaying teeth or need for adequately fitting dentures, in the space available. Be specific when asking about dentures (i.e., "Do you have dentures?", "Are they causing pain?", "Do they fit properly?")

- **Other** means to specify other problem(s) that make it difficult for the client to eat.

Current Medical Services (UAI, Page 7)

Rehabilitation Therapies (UAI, Page 7)

Record all medical-social rehabilitation therapies professionally prescribed and currently administered by qualified trained personnel to maintain the client's present status or to improve or resolve a complication or condition resulting from an illness or injury. Do not include maintenance activities provided by untrained, non-professionals (e.g., the continuation of therapy which is not under direct supervision of a trained therapist).

- **Occupational Therapy** is training in self-care activities to improve functioning in ADLs/IADLs.

- **Physical Therapy** includes treatments of the muscular system to relieve pain, restore function and/or maintain performance.

- **Reality/Re-motivation** includes small group activities to stimulate awareness, interaction, verbalization, self-esteem and self-sufficiency.

- **Respiratory Therapy** includes chest therapy, breathing treatments and inhalation therapy.

- **Speech Therapy** includes services to correct and improve speech and language.

Pressure Ulcers (UAI, Page 7)

A pressure ulcer is ulceration or dead tissue overlying a bony prominence that has been subjected to pressure or friction. Other terms used to indicate this condition include

bedsores and decubitus ulcers. If a pressure ulcer(s) is/are present, record the highest stage or most severe ulcer on the client's body. Note the location and approximate size of the ulcer if known.

- **Stage I** is a persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Stage I ulcers commonly appear on parts of the body that protrude out, such as elbows.

- **Stage II** is a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

- **Stage III** is a full thickness loss of skin, exposing the subcutaneous tissues which presents as a deep crater with or without undermining adjacent tissue.

- **Stage IV** is when a full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.

Special Medical Procedures (UAI, Page 7)

Record all treatments *ordered by the client's physician(s)*. These include procedures administered by the client or family or those provided or supervised by licensed nursing personnel. If the procedure is not self-administered, make note of the person providing the treatment. For all procedures, record the site, type and frequency.

- **Bowel/Bladder Training** is training to restore control of bowel or bladder functioning. Programs to control the timing of involuntary bowel/bladder emptying are not considered special medical procedures.

- **Dialysis** is the mechanical purification of the blood by filtering toxins or poisons from the blood, a function normally performed by the kidneys.

- **Dressing/Wound Care** is the application of material to any type of wound that is more than a simple redness or abrasion (e.g., pressure ulcer, surgical wound, skin tear, second-degree or third-degree burn) for the purpose of promoting healing, for exclusion of air or for the absorption of drainage.

- **Eye care** refers to the administration of prescribed eye drops or ointment.

- **Glucose/Blood Sugar** is the routine testing or monitoring of sugar level in the blood.

- **Injections/IV Therapy** includes injections (shots) administered by the client, caregiver, or health care professional, or professional teaching on the administration of injections.

- **Oxygen** is the use of continuous or intermittent oxygen via nasal catheter, mask or oxygen tent.

- **Radiation/Chemotherapy** is the treatment of cancer with radiation or drug therapy.
- **Restraints** are uses of appliances (physical) or medications (chemical) to restrict/confine movement.

- **Range of Motion (ROM) Exercises** are exercises prescribed to move joints through full motion.

- **Trach Care/Suctioning** is the cleaning or changing of an artificial (or mechanical) airway in the trachea.

- **Ventilator** care is the care of ventilator dependent clients. These clients are unable to breathe on their own or are unable to breathe deeply or often enough to maintain an adequate level of oxygen in the blood.

Medical/Nursing Needs (UAI, Page 7)

Ongoing Medical/Nursing Needs (UAI, Page 7)

Based on the client's overall condition, the assessor should evaluate whether the client has ***ongoing*** medical and/or nursing needs. An individual with medical or nursing needs is someone whose health needs require medical or nursing supervision, or care *above the level* which could be provided through assistance with activities of daily living, medication administration and general supervision, and is not primarily for the care and treatment of mental diseases (mental diseases applies to conditions of mental illness; it does not include conditions of dementia/Alzheimer's disease). Medical or nursing supervision or care is required when any one of the following describes the individual's need for medical or nursing supervision:

- The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self observe and/or evaluate the need to contact skilled medical professionals; or

- Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

- The individual requires at least one ongoing medical/nursing service. The following is a non-exclusive list of medical/nursing services which may, but need not necessarily, indicate a need for medical or nursing supervision or care:

a. Application of aseptic dressings;
b. Routine catheter care;
c. Respiratory therapy;
d. Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have recent history of weight loss or inadequate hydration which, if not supervised, would be expected to result in malnourishment or dehydration;
e. Therapeutic exercise and positioning;
f. Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;
g. Use of physical (e.g., side rails, poseys, locked wards) and/or chemical restraints. Note: This would cover those individuals with Alzheimer's disease who have attained that stage of the disease where they cannot be safely managed unless in a locked ward or in a posey restraint. This describes a level of care, which could not be managed in a home for adults or in a private home, but continues to exclude the individual with early Alzheimer's disease who just requires some supervision and reminders;
h. Routine skin care to prevent pressure ulcers for individuals who are immobile;
i. Care of small, uncomplicated pressure ulcers and local skin rashes;
j. Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;
k. Chemotherapy;
l. Radiation;
m. Dialysis;
n. Suctioning;
o. Tracheostomy care;
p. Infusion therapy; or
q. Oxygen.

"Ongoing" means that the medical/nursing needs are continuing, not temporary, or where the patient is expected to undergo or develop changes with increasing severity in status. "Ongoing" refers to the need for daily direct care and/or supervision by a licensed nurse that cannot be managed on an outpatient basis.

Specify the ongoing medical/nursing needs in the space provided. A client who is receiving rehabilitation services and/or a special medical procedure does not automatically have ongoing medical/nursing needs.

For nursing home preadmission screening purposes, patients with early states of dementia/Alzheimer's disease who require some supervision and reminders will NOT have developed medical/nursing needs. However, as the disease progresses, the individual will require daily observation and assessment to prevent destabilization. The areas of

observation frequently include supervision for adequate nutrition and hydration due to recent history of weight loss or inadequate hydration or the use of physical/chemical restraints.

In addition, a person with dementia can be determined to have medical/nursing needs even if the individual's current medical condition appears stable. Such individuals are usually unable to self-observe and/or report any physical symptoms of illness, are unable to control adequate food and fluid intake without close supervision, and may require, depending on behavior pattern, the use of a physical or chemical restraint or must be restricted to a secured environment. However, if the individual being assessed is seeking nursing facility placement or Elderly and Disabled Waiver services, the screening committee must determine that the individual cannot be maintained in an alternative institutional setting.

Signatures (UAI, Page 7)

At the bottom of the page is space for the physician's signature. There is also space for the signature of others, such as a facility administrator. Depending on the type of assessment being performed, these signatures may or may not be optional. The purpose of the signature is to certify that the information found in the physical health section of the assessment is accurate and complete.

SECTION IV. PSYCHO-SOCIAL ASSESSMENT

The presence of cognitive problems and mental impairments can have an impact on the ability of a client to live independently. Cognitive problems are caused by a variety of diseases and conditions. Of all the losses suffered by a client, cognition is the most difficult to assess and handle, and it has the most pervasive effect on overall functioning. Cognitive impairments can affect a person's memory, judgment, conceptual thinking and orientation. In turn, these can limit the ability to perform ADLs and IADLs. When assessing clients for possible cognitive impairment, it is important to distinguish between normal minor losses in intellectual functioning and the more severe intellectual impairments caused by cognitive disorders such as Alzheimer's Disease or Organic Brain Syndrome (OBS). Some intellectual dysfunction may be caused by a physical disorder or by side effects or interactions of medications.

In some cases, you may want to ask the cognitive questions at the beginning of the interview. This may be appropriate for a client when it becomes apparent during the initial time with him or her that he or she may not be capable of participating in the full assessment process or that you may not be able to obtain meaningful information directly from the client.

Cognitive function questions should be approached in a very matter-of-fact manner. The interviewer should state the following instructions: "Sometimes people have trouble remembering things. If you do not know the answers to some of the next questions, that's okay. On the other hand, some of the answers may seem obvious." Do not make the client think that answering the questions is a pass/fail situation. If clients seem disconcerted by the questions, try to reassure them that they are doing fine. Then go on quickly to the next question. If you indicate to the client that his answers are correct or incorrect, increased anxiety may cause the client to miss other questions. Do not assume you know the client's answer to a particular question if you have not asked the question.

Remember to pay attention to the client's appearance, behavior and way of talking throughout the complete interview. This may give clues about his or her cognitive and emotional functioning. *It is important to remember that you are not diagnosing the client, but rather you are looking for some indicators of the possible need for a referral to the local Community Services Board (CSB) or other mental health professional for a more thorough mental health and/or substance abuse assessment and possible diagnosis.* (See Appendix K for a list of indicators for mental health referrals).

This section includes both required and optional cognitive questions. The required questions assess the client's cognitive function in a more general manner. The optional questions are from a validated instrument and can be used to develop a cognitive impairment score. This score then can be used to determine when a referral to a mental health provider is needed.

Required Questions. The six required questions are noted on the UAI in the shaded boxes and are in bold type. These questions are of a more general nature and are the minimum number of questions needed to measure cognitive function. Clients are asked three questions related to orientation (person, place and time), two for memory (short and long), and one for judgment.

Optional Questions. There are four optional questions that comprise a modified version of the Mini-Mental State Examination (MMSE) (Paveza, Gregory J. *A Brief Form of the Mini-Mental State Examination for Use in Community Care Settings.* ***Behavior***, Health and Aging, Vol 1, 1990.) These questions address the client's awareness of place and time, recall and attention/concentration. The optional questions and instructions are written in italics located in shaded boxes on the UAI. The optional questions take the required questions one step further by prompting the client to provide more specific details. For example, instead of limiting the required question on time to "Would you tell me the date today?", ask the client for five specific areas of time (year, season, date, day, and month). Give the client one point for each of the five time questions that are answered correctly. The following section includes instructions for the MMSE in boxes with italic type.

Cognitive Function (UAI, Page 8)

Orientation (UAI, Page 8)

Ask the questions on the survey related to the cognitive spheres - person, place and time - in order to evaluate orientation, or the client's awareness of his environment.

- **Person:** Alternative questions to assess orientation to person are "Please tell me the name of your next door neighbor" or "Please tell me the name of the staff person who takes care of you." The preference, however, is that the assessor ask the question as written on the assessment instrument. There are no MMSE questions for orientation to person.

- **Place:** For orientation to place, the complete mailing address, *excluding* zip code, is required. It may be necessary to probe for more details when clients give answers such as "My house" or "My room." See the box below for instructions on the optional MMSE question related to Place.

MMSE Question #1 (Place): Where are we now? Give the client 1 point for each correct response; the maximum number of points is 5. Ask for the (1) state, (2) county, (3) town, (4) street number and (5) street name. These categories can be modified for clients in rural areas by substituting route and box number for street number and name. For hospitalized

clients, substitute hospital and floor for street number and name. For clients in a community setting, substitute agency and floor for street number and name.

- **Time:** For orientation to time, the month, day, and year are required. See box below for instructions on the optional MMSE question related to Time.

MMSE Question #2 (Time): Would you tell me the date today? Give the client 1 point for each correct response; the maximum number of points is 5. Ask for the (1) year, (2) season, (3) date, (4) day, and (5) month. The assessor may state that "date" means "1st, 2nd, etc." and "day" means "Monday, Tuesday, etc."

Based on the client's answers to the questions on Person, Place, and Time, code his or her level of orientation/disorientation. A client is considered disoriented if he or she is unable to answer any of the questions. In order to code the specific type of disorientation, it may be necessary to consult a caregiver about the spheres affected and the frequency (i.e., some of the time or all of the time). Use the space provided to record the sphere(s) in which the client is disoriented.

- **Oriented** means the client has no apparent problems with orientation and is aware of who he or she is, where he or she is, the day of the week, the month, and people around him or her. **(I = Independent)**

- **Disoriented, Some Spheres, Some of the Time** means the client sometimes has problems with one or two of the three cognitive spheres of person, place, or time. *Some of the Time* means there are alternating periods of awareness-unawareness. **(d = Semi-dependent)**

- **Disoriented, Some Spheres, All of the Time** means the client is disoriented in one or two of the three cognitive spheres of person, place, and time, *All of the time* means this is the client's usual state. **(d = Semi-dependent)**

- **Disoriented, All Spheres, Some of the Time** means the client is disoriented to person, place, *and* time periodically, but not always. **(D = Dependent)**

- **Disoriented, All Spheres, All of the Time** means the client is always disoriented to person, place, *and* time. **(D = Dependent)**

- **Comatose** means the client is in a semi-conscious or unconscious state or is otherwise non-communicative. **(D = Dependent)**

Recall/Memory/Judgment (UAI, Page 8)

- **Recall:** After the introductory statement, say the words **HOUSE, BUS, DOG**, and ask the client to repeat them.

This first repetition determines the score for MMSE Question #3 (Recall). Give the client 1 point for each correct answer. The maximum number of points is 3.

Repeat the words for up to 6 trials until the client can name all three. Tell the client to hold them in his or her mind because you will ask him or her again in a minute or so what they are. The client's ability to repeat the words later is the assessment of short-term memory.

- **Attention/Concentration:** This is the only question which is strictly for use in the MMSE.

MMSE Question #4 (Attention/Concentration): Spell *the word WORLD. Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW). The maximum number of points is 5.*

Note: If the client is unable to spell, serial sevens may be used as an alternative. By this, the assessor asks the client to subtract by sevens from 100 (i.e., 93, 86, 79, 72, 65. . .). After the client has completed five subtractions, you can ask him or her to stop. Give 1 point for each of five correct responses.

MINI-MENTAL STATE EXAMINATION SCORING:
Compute the MMSE Score as the total number of points for the Place, Time, Recall, and Attention/Concentration questions. Each person's educational and cultural background should be taken into account as to how it might affect the MMSE score. The maximum score is 18. A score of 14 or below implies cognitive impairment, but does not mean that the client has a diagnosis of dementia. There may be other contributing factors to poor cognitive function, such as physical health or medication problems. If the client scores 14 or below, information collected during the assessment interview should be verified with a caregiver. When no other source exists, do the best you can with the client, and note that the information may not be reliable.

- **Short-Term Memory:** Ask the client to recall the 3 words that you previously asked him or her to remember. If you are not administering the MMSE, you may want to ask the long-term memory question before this question so that some time has passed since you asked the client to remember the 3 words. A possible short-term memory problem is indicated if the client is unable to recall all 3 words: **House, Bus, and Dog.**

- **Long-Term Memory:** Long-term memory is the ability to remember the distant past. Ask the client his or her date of birth in order to evaluate long-term memory loss. Memory loss is indicated when the client is unable to give his or her complete date of birth (the month, date, and year).

- **Judgment:** Judgment is the ability to reason and make decisions. Ask the client to describe the steps he or she would follow to obtain help at night. In assessing the client's response, look for an answer that is appropriate to where the person resides. It may also be helpful to gain insight from others who know the client.

Behavior Pattern (UAI, Page 8)

☞ **This question is not designed to be asked directly of the client. The answer is based on the assessor's judgment based on observation and information gathered about the client.**

This question assesses the way the client conducts himself or herself in his or her environment. It taps three types of behavior: wandering, agitation, and aggressiveness. Other things to consider include: 1) whether the client ever engages in intrusive or dangerous wandering that results in trespassing, getting lost, or going into traffic; 2) whether the client gets easily agitated (overwhelmed and upset, unpleasantly excited) by environmental demands; 3) whether the client becomes verbally or physically aggressive when frustrated; 4) whether the client becomes resistive or combative toward the caregiver when assisted with ADLs; 5) paces but does not wander; 6) is passive, oppositional, or restless; 7) repeats verbal statements; or 8) is combative or destructive. If several of the responses could describe the client, code the most dependent.

- **Appropriate** means the client's behavior pattern is suitable to the environment and adjusts to accommodate expectations in different environments and social circumstances. **(I = Independent)**

- **Wandering/Passive - Less than Weekly** means the client physically moves about aimlessly, is not focused mentally, or lacks awareness or interest in personal matters and/or in activities taking place in close proximity (e.g., the failure to take medications or eat, withdrawal from self care or leisure activities). The client's

behavior does not present major management problems and occurs less than weekly. **(I = Independent)**

- **Wandering/Passive - Weekly or More** means the client wanders and is passive (as above), but the behavior does not present major management problems and occurs weekly or more. **(d = Semi-dependent)**

- **Abusive/Aggressive/Disruptive - Less than Weekly** means the client's behavior exhibits acts detrimental to the life, comfort, safety and/or property of the client and/or others. The behavior occurs less than weekly. **(D = Dependent)**

- **Abusive/Aggressive/Disruptive - Weekly or More** means the abusive, aggressive, or disruptive behavior (as defined above) occurs at least weekly. **(D = Dependent)**

- **Comatose** refers to the semi-conscious or unconscious state. **(D = Dependent)**

Specify the type of inappropriate behavior and the source of the information in the space provided.

Life Stressors (UAI, Page 8)

Record all stressful events currently affecting the client's life. Stressful events may have an impact on the client's emotional health and include such things as the death of a spouse or close friend, institutionalization, hospitalization, family conflict, financial problems, changes in living arrangements, or change in recent employment (recent retirement). Record as *Other* any other events mentioned by the client but not included in the list of responses.

Emotional Status (UAI, Page 9)

These questions are very personal, and some clients may feel threatened or insulted by them. If the assessor seems uncomfortable, the client will sense this and probably feel uncomfortable as well. The assessor might say some things to help ease, or even prevent, any discomfort the client might feel, such as "Now I need to ask you some questions that may seem unusual, but I want you to know that we ask these questions of everyone. My asking the question does not mean that I think these things are characteristic of you. For example, when I asked if you had a hearing problem, it was not because I thought you had one, but because I need to know that about everyone I talk with. The only way for me to know whether you have a problem, and be able to help with it, is to ask you. So, I hope

you'll help me with these next questions, because I need to ask you, even if they seem unrelated to you."

Be sensitive to and observant of the client's responses. The client's reactions to the questions are important, as well as his or her answers.

Ask these questions in a straightforward and direct manner and be sure you and the client interpret the question in the same way. Record the frequency of each emotional state *within the past month*. There is space to record when you are *Unable to Assess* due to a client's refusal to answer.

- **Rarely/Never** means seldom or never.
- **Some of the Time** means occasionally (1 time per week).
- **Often** means frequently (2-3 times per week).
- **Most of the Time** is nearly always (4 or more times per week).

Answers to these questions may indicate the need for further assessment. *Appendix K provides guidelines on when to refer a client to the local CSB or other mental health professional for further assessment.*

Social Status (UAI, Page 9)

Activities (UAI, Page 9)

This question asks about types of activities which the client enjoys doing. For each type of activity, use the space provided to describe the specific activity and the frequency. These answers are not mutually exclusive, and activities may fall into more than one category.

- **Solitary Activities** are done alone and may include, but are not limited to, reading, watching T.V. and gardening.
- **Activities with Friends/Family** may include, but are not limited to, talking on the telephone and visiting.
- **Group/Club Activities** may include attending nutrition sites or senior centers and participating in group-sponsored trips.
- **Religious Activities** may include attending religious services or participating in group meetings.

Interactions (UAI, Page 9)
This question asks about the frequency of the client's contacts with children, other family, and friends/neighbors. If the client has children, other family, and friends/neighbors, record how often contact (through a visit or over the telephone) occurs. This information is important in order to assess the client's contact with others outside the home and his or her potential for being or becoming socially isolated. The last question asks the client if he or she is satisfied with his or her general level of social contact.

Hospitalization/Alcohol-Drug Use (UAI, Page 10)

Hospitalization (UAI, Page 10)
Record whether or not the client has been hospitalized or received inpatient/outpatient treatment in the last 2 years for emotional, mental health, or substance abuse problems. This includes any participation in alcohol or drug rehabilitation programs. If the answer is yes, ask the client where or from whom he or she received mental health services or counseling.

Record the name of the place, the admission date, the length of stay and reason for admission/treatment. It is not necessary to record the exact admission date. An approximate date, such as "11/98," will suffice. For outpatient treatment, record the name of the place, the date of the last visit and the reason. If there have been multiple admissions/treatments in the last 2 years, only record the most recent in the space provided. Use the space available to record information about other less recent hospitalizations and/or treatments.

Alcohol/Drug Use (UAI, Page 10)
Record whether or not the client currently drinks, or has ever drunk, alcoholic beverages. If the client currently drinks, it is important to determine specifics about how much and how often the client drinks. Determine the average number of drinks per day, week, or month, using probes when necessary to clarify vague answers (e.g., "a few drinks every now and then"). It is very important to determine what "a drink" means to the client. Ask questions to determine what type of alcohol the client usually drinks and the average quantity in ounces of each drink. As a guide for what to record, count one drink for every one ounce of liquor, five ounces of wine, or twelve ounces of beer. It is important to also know the amount of ounces in each drink.

In the second question, record whether or not the client currently uses, or has ever used, non-prescription, mood-altering substances. If the client currently uses, record how much and how often.

> ☞ **If the client has never used alcohol or other non-prescription, mood altering substances, skip the next three questions and ask the smoking/tobacco question.**

Record whether there has ever been concern about the client's use of alcohol or other non-prescription, mood altering substances. Use the space to provide details. The next question asks for information about the use of alcohol or mood altering drugs with other substances. The third question asks for information about why the client uses (or used) alcohol or mood altering drugs. Use the space to provide details. *A referral to the Community Services Board or another mental health professional should be considered when a client reports currently drinking more than 2 drinks of alcohol per day, or when there is current use of non-prescription, mood-altering substances (e.g., marijuana, amphetamines).*

Smoking/Tobacco Use (UAI, Page 10)

Smoking refers to the client's status with respect to smoking and/or using tobacco products (cigarettes, snuff, chewing tobacco). Record whether the client has a history of, or currently, smokes or uses tobacco products. If the client currently smokes or uses tobacco, record the number of cigarettes/amount of tobacco and the frequency (per day, per week, etc.).

Additional Information (UAI, Page 10)

The last question in this section asks the client if there is anything else he or she would like to discuss. This gives the client the opportunity to raise any issues that have not been addressed directly during the Psycho-Social Assessment and/or to elaborate on previously discussed issues.

SECTION V. ASSESSMENT SUMMARY

According to Section 63.1-55.3 of Virginia law, any person employed by a public or private agency or facility and working with adults is mandated to report suspicion of abuse, neglect, or exploitation of adults. If, during the course of the assessment, the assessor suspects abuse, neglect, or exploitation, he or she must report it to the local department of social services, Adult Protective Services. Appendix H contains indicators of possible adult abuse and neglect.

Caregiver Assessment (UAI, Page 11)

Informal care refers to services the client's spouse, relative or other person(s) are both physically and mentally *able and willing* to provide, at all the times the services generally are needed. If the client does not currently have an informal caregiver who actively provides assistance, note this on the form and skip to the Preferences Section.

> ☞ **The caregiver questions are not written to be asked directly of the client or caregiver**. **They are to help the assessor determine if care giving is adequate.**

In the first question, record if the caregiver lives with the client, in a separate residence within 1 hour of the client's home (close proximity), or in a separate residence over 1 hour away. In the next question, record whether the caregiver's help is adequate to meet the client's needs. *Adequate* means the caregiver is *able and willing* to provide for all of the client's needs, at all times they are needed. The last question assesses how burdened the caregiver feels in caring for the client.

Use the space provided to record any problems with continued care giving. These may include, but are not limited to, poor health of the caregiver, employment of the caregiver, caregiver's lack of knowledge about ways to appropriately care for the client, or a poor relationship between the client and the caregiver. The space can also be used to record whether the caregiver has a "backup," or someone else who can provide for the client when the caregiver is unavailable or unable.

Preferences (UAI, Page 11)

Record the types of care the client and his family prefer. There is also space for comments by the client's physician. People's preferences let the assessor know if there are consistent or differing opinions about the best care for the client.

Client Case Summary (UAI, Page 12)

Use this section to explain, describe and specify important information from the client that cannot be recorded elsewhere in the assessment tool. This section can also be used to: 1) record relevant detail that does not fit into other spaces; 2) record assessor observations which may support or contradict what the respondent answers; 3) record interviewer judgment or conclusions; 4) record someone else's opinion which differs from the client's answer; or 5) make a note to yourself.

Unmet Needs (UAI, Page 12)

Record all unmet needs as indicated by the assessment. An unmet need is an identified need which is not currently met in a way ***that ensures the safety and welfare of the client***. For example, a client's primary caregiver may help the client with ADLs, but the caregiver is burdened and unable to continue providing the current level of care. In this case, the client would have at least unmet needs for ADL assistance and caregiver support. There may be other unmet needs according to the client's particular situation.

Completion of the Assessment (UAI, Page 12)

All individuals completing parts of the full assessment should record their names, the agency/provider for whom they work, the provider number (for all Medicaid-certified providers), and the sections completed.

Optional (UAI, Page 12)
Record the name and code of the case manager assigned the case. This information can be used to track the case manager's caseload and other management activities.